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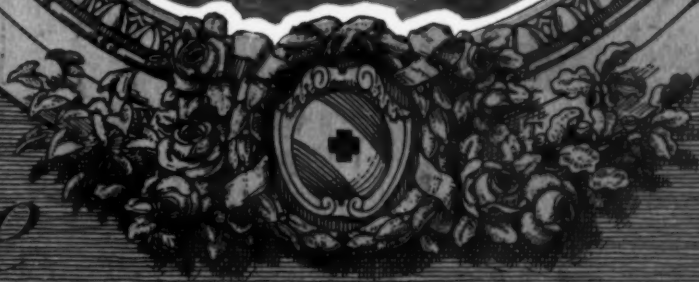
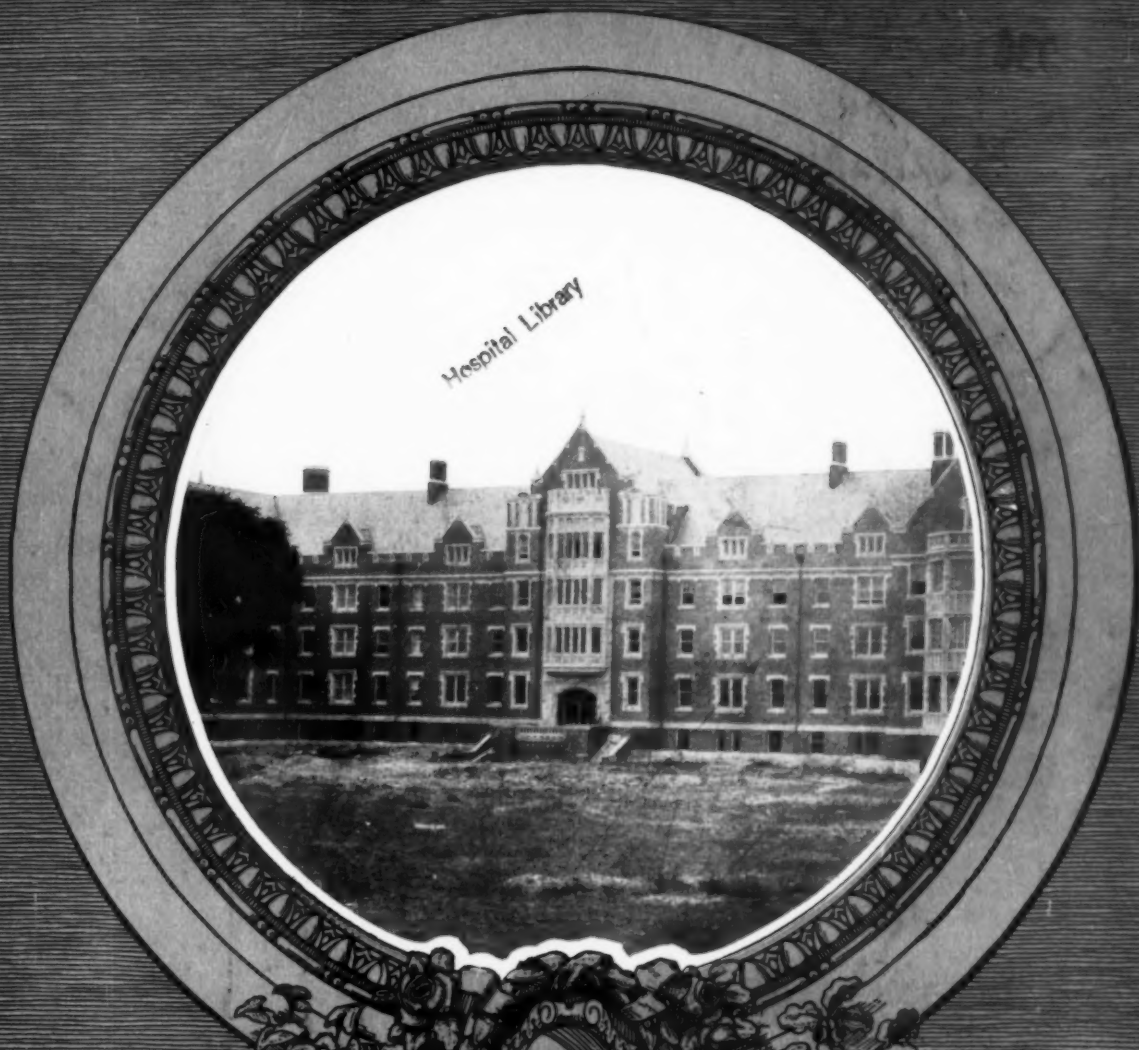
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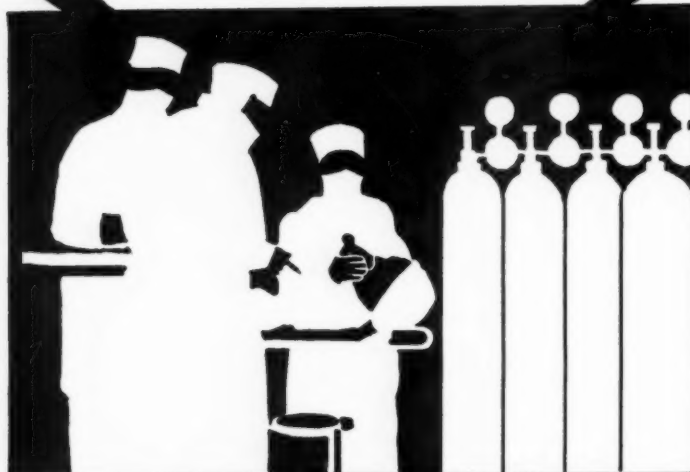
The MODERN HOSPITAL

Vol. XXXVII DECEMBER, 1931

No. 6



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THE MODERN HOSPITAL



A Monthly Journal Devoted to the Construction, Equipment, Administration and Maintenance of Hospitals and Sanatoriums.

VOL. XXXVII

December, 1931

NUMBER 6

The Board—The Power Behind the Hospital's Success

By HOWARD S. CULLMAN

President, Beekman Street Hospital, New York City

MANY a hospital's business problems would be solved if the nature, functions and qualifications of board members could be permanently defined. Why, therefore, is a trustee and what type of person should he be?

Should a trustee be an individual whose wealth and age make him a likely prospect for a rich bequest, despite his lack of any active interest in the institution? Should he, on the other hand, be a man whose interest is so keen that it extends over into professional matters—the type of trustee who is forever boosting the appointment of his nephew to the medical board? Should he be an eminently respectable citizen whose social position serves as good window dressing, while his total lack of social consciousness deters him from any active part in the hospital's work? Should he be chosen because he is a church deacon whose piety appeals to some of the more religious contributors despite the fact that he is more interested in saving the souls than the bodies of the sick?

All will agree that he should be none of these. On the other hand, to define precisely the nature and functions of the ideal director is not easy. He should be, in any case, a man of alert and intelligent interest in hospital matters, capable of keeping its business mechanism smoothly running. His responsibility is twofold—seeing that ample funds are provided and lending aid, supervision and

interest to all the practical or lay aspects of the hospital's work. He must make one essential renunciation—he must leave to professional men and specialists all matters that may be classed as definitely professional and scientific.

To apply business principles to the hospital is, then, no easy task. It is further complicated by the fact that the hospital, whether municipal or private, is not a commercial enterprise. It is a humane institution not measurable by the popular standards of business, an institution often hampered by grotesque deficiencies in community planning such as could never exist in the world of commerce.

In New York City, for example, the distribution of our hospitals still bears witness to a century of haphazard benevolence. Our first public hospital sprang into being in 1736 on the present site of City Hall, with six beds and a small clinic. Shortly thereafter New York Hospital was created, followed by the sporadic growth of a number of private and municipal institutions that were opened in response to community needs. Concurrent with these, hospitals sponsored by various fraternal organizations, sectarian and foreign born groups came into being. Never, until very recently, has there been anything remotely resembling regional planning; nor were hospitals subject to that wholesome weeding out by competition that would

make such a situation commercially impossible. The case of New York City, however, is not unique.

Historically, then, we are not dealing with a philanthropic system that developed logically, as commercial growth is judged. We are confronted with a situation which is, from a managerial point of view, extremely involved. Practically, we are striving for humane results that cannot be measured in dollars and cents but that depend, none the less, on dollars and cents for their fulfillment.

More Than Superficial Interest Is Needed

In theory at least, most hospital trustees are heart and soul behind the high purposes of the hospitals. Certainly they would like to see the sick cared for by the highest grade of professional service available and they are eager to foster every possible advance of science. Yet there are on record innumerable cases of petty political meddling that have resulted in serious dissension and even in the actual failure of institutions. The morale of a medical board is frequently undermined by unwarranted intrusions of trustees. If, however, the presumptuousness of lay excursions into purely professional fields were brought to the attention of the offending trustee, he would agree that they have no justification.

Yet, eager as many directors seem to have a finger in the medical pie, just so reluctant have they appeared to take the lead in investigating and directing the vast body of administrative and practical details that come within their rightful province. In the metropolitan district of New York City, the hospitals have an appraised valuation of over \$170,000,000 and spend annually a sum over \$61,000,000. Yet the huge task of administering and controlling an investment of these proportions is relegated largely to superintendents and their assistants—specialists whose training and background frequently provide them with few qualifications for the business aspects of their work.

The average director feels that he is doing his bit if he helps to raise money for and contributes to actual maintenance charges or expansion programs. On the other hand, his efficient performance of even this task is hampered by the delusion, popular among trustees, that a healthy deficit is in some way praiseworthy and its converse, a sizable surplus, disputable. In my estimation a deficit proves only one thing—the inadequacy of the board as money raisers. It is no index to the quality or quantity of the hospital's good works. To substantiate this point, I can name at least one institution whose achievements are beyond reproach that is annually afflicted with a shocking

surplus; and I know of other institutions, boasting magnificent deficits, whose treatment of the indigent is niggardly and whose professional standards are deplorable. Obviously neither a surplus nor a deficit is a check on hospital success. Efficiency can be judged only by a comprehensive grasp of the individual hospital's practical problems.

And it is such a grasp that the superficial interest of the average trustee renders impossible. Although New York City hospitals spend annually over \$61,000,000, it is questionable whether the average trustee has any analytical conception of his hospital's budget. In the average institution, house, ambulance and finance committees are mere paper set-ups, with the meetings rarely attended. It is also characteristic of the unbusinesslike spirit pervading hospital management that, with few exceptions, no attendance records are kept of board or committee meetings.

The result has been that the average director is fond of judging his superintendent's efficiency by such convenient indexes as per capita cost. If the superintendent reports a seven-cent per diem rise, he is met with black looks; if, on the other hand, he can boast a five-cent cut, cheers greet him. Yet, to the least profound mind, it must be apparent that such statistics, unanalyzed, are insignificant and frequently misleading. Rule of thumb methods give no picture of medical service, nursing standard or food quality. Their only excuse is an intellectual indolence to which the average trustee must plead guilty.

Who Is to Blame?

Can there be any other explanation for the really shockingly poor business tactics of our hospitals? Is there any excuse for the prevalence of accounting systems so unstandardized that a really comparative study of costs is almost impossible? Is there any possible justification for the labor situation in our hospitals? Although the item of wages consumes over two-fifths of the \$61,000,000 budget, a complete lack of uniformity in wage scales and organizations has resulted in a labor turnover large enough to wreck the average business. What reason can there be for the lack of cooperation in such matters as obtaining ambulance appropriations in a day when the least enlightened business man has learned to make use of trade associations? Whom shall we blame for uneconomic buying methods, for the failure to control procedures, for the complete lack of any means of training future hospital executives and for the total nonexistence of any reasonable estimate of nursing costs? Who is responsible for the highly sentimental, often maudlin appeals for

funds that our hospitals send forth when experience has proved the superiority of the straight from the shoulder appeal? I am convinced that these and a hundred other instances of bad management could never exist, were hospital directors more than trustees in name only.

A Challenge to the Conscientious Trustee

Nor would any trustee who had taken the trouble to analyze his hospital's budget tolerate such an abuse of philanthropy as is now being practiced in workmen's compensation cases. The hospital of which I am president, handles, from a percentage standpoint, probably more compensation cases than any other in the community. As a result, our board, after giving the problem a great deal of thought, has reached the conclusion that hospitals should be fully reimbursed by insurance companies for the cost of these cases and that the public should not be burdened with the difference between the actual cost and inadequate payments. I think anyone familiar with our compensation act will support the soundness of this point of view. Yet in our hospital, supposedly a philanthropic institution, we must contend with neighbors who, apparently with the support of their trustees, are competing at cut rates for compensation cases. That such a policy is, to say the least, economically unsound, the recent closing of one such institution in New York City proves. This calamity could undoubtedly have been avoided by a study of the hospital's budget which would have revealed a steadily mounting deficit due to the discrepancy between the cost of and payment for compensation cases. But this group of trustees did not apparently regard a careful scrutiny of departmental activities and comparative costs as a part of its job, with the result that the deficit remained an unexplained mystery resulting in catastrophe.

Group planning and cooperative action alone can solve such difficulties. I am keenly aware of the obstacles in the cooperative path. I realize that the loose classification of our hospitals as "municipal" and "private" leads to the impression of great complications. Yet is not, in reality, the term "private" hospital a misnomer? The vital work of any hospital is in its clinics, wards and social service departments. While the private hospital is, in contradistinction to the municipal hospital, run by a continuous board of directors not subject to political control, does not the public in either case foot the bill whether in the form of donations or of taxes? Certainly insofar as function goes, there is nothing "private" about a private hospital.

Logically, this brings us to a more searching

question. What, from a business point of view, is the justification of the private hospital? If I were sure that the sinister hand of politics could be kept out of all state or municipal institutions, if I were certain that the same opportunities for research would be maintained and if I were convinced that facilities would be adequately and equitably distributed, I would answer without reservation that the private hospital has no justification. Certainly a unification of the entire hospital system would, under ideal circumstances, help straighten out the economic situation.

Unfortunately, viewing the field as a realist, to-day, I am aware that the need for private hospitals still exists. The millennium is not yet at hand; and the time is not yet ripe for a completely state operated system. But we need wait for no millennium to apply business principles to the hospitals as we find them. Here and now, I wish to put in my pleas for more intelligent and more responsible trustees; for the abolition of the dummy board that has served many a bank ill and that can do the same for the best intentioned hospital; for some attempt at community cooperation that shall result not in a stultifying uniformity but in a heightened and flexible efficiency. And I believe that these ends can be reached if directors will apply to their hospital posts at least a part of the economic wisdom they bestow so lavishly upon their commercial endeavors.¹

How New Treatment of Osteomyelitis Was Discovered

The story of how the maggot treatment came to be used in the relief of osteomyelitis is recalled in connection with the erection of a new building at the Children's Hospital, Baltimore, in which will be set aside a hyper-modern treatment room as a monument to the memory of the late Dr. William Stevenson Baer, famous Baltimore orthopedic surgeon.

In his work as a war surgeon, Doctor Baer treated many cases of soldiers who had been brought to him suffering from bone diseases. They had been lying on the battlefield for days. According to all the laws of nature, they should have been dead. In his examination, Doctor Baer discovered they had been kept alive by maggots that had penetrated into the diseased parts of the bone and had eaten them all away.

After the war he began to experiment and as a result many children have been helped.

¹Read at the Hospital Standardization Conference of the American College of Surgeons, New York City, October 12-15.

Mending Crippled Minds With Modern Therapeutic Aids

By MAX A. BAHR, M.D.

Superintendent, Central State Hospital, Indianapolis

THE treatment of patients by recreational and diversional occupation is an essential feature in every modern state hospital for mental diseases. It is now generally agreed that occupational therapy together with recreation and amusement constitutes one of the best available methods of treating mental patients.

If a patient can be interested in something outside of himself and be made happy it will aid his recovery. Arousing the patient's interest, therefore, is of the greatest importance and may be considered the primary object to be attained in cases in which occupation is prescribed.

In this form of treatment it becomes absolutely necessary to enlist the cooperation of the patient before occupation is prescribed and to explain to him why it is advisable for him to carry on some form of activity. This suggestion must be made tactfully, for, especially in cases with delusions,

antagonistic attitudes are frequently encountered.

In the administration of such a program of treatment many considerations must be constantly borne in mind. The treatment must be prescribed and administered under the advice of the medical officer and treatment in each case must be individualized and graded according to the patient's strength and capacity and the interest he displays. The chief occupational therapist should be well trained in arts and crafts and skilled in dealing with mental cases. He should have enthusiasm, vision, initiative, tact and a background of successful experience.

Occupational therapy is of value in treating mental cases because of its infinite variety—its adaptability to innumerable individual tastes and capacities, its range from utmost simplicity to the highest degree of complexity, which makes it an avenue by which the unfortunate may readily re-



Here we see the men making toys, furniture, brooms, mops, baskets and doormats, work that is part of the hospital's plan for the treatment and rehabilitation of its patients.



This display shows samples of the many types of work done in the occupational therapy department.

turn to normal life. Wandering attention is trained anew to concentration; distracted thoughts are pushed into the background; delusive concepts and hallucinations are crowded out of consciousness by demands of reality; depression and a feeling of inefficiency are banished by the encouragement of commendation, and self-respect is built up again by successive achievements which are tangible and afford satisfaction as they do in a healthy state. The sight of other patients variously engaged excites a desire for corresponding activity in the mind of one who is inclined to be idle.

It is necessary to emphasize the diversional feature in order to obtain the best therapeutic results. This can be done in a variety of ways according to individual temperament. For some the change to another kind of occupation induces new zest; for others the introduction of a social phase, such as music and dancing, or some form of competition, gives the work a flavor of play or a pleasing admixture of it.

The economic value of the employment of patients is difficult to compute. Although this is not the essential aim in the program, enough revenue can be obtained from the sale of products to pay for the various supplies purchased and for some of the amusement features supplied for the patients. The incomputable value is found in the diminution of loss from destructive tendencies associated with the aimless activity of some patients when they are not employed and the reduced cost of supervision and attendance resulting from the improvement in their habits of destructiveness, disorder and violence. A conservative estimate at the Central State Hospital, Indianapolis, is that

five thousand dollars' worth of property is conserved each year by providing occupational therapy as an outlet for the activity of our patients.

Rug weaving is a form of diversional occupation that affords a great many opportunities for specialized activities. There are several distinct subdivisions of this work, and each can be used with special advantage in treating the particular behavior in the various types of mental diseases. The subdivisions of this work include collecting, sorting, sewing, reeling and weaving. The preparation of the loom requires exceptional skill and accuracy. The warping of the beams and the tying in of each thread in the warp are tedious work and require experience and patience. Turning waste material into new hospital utilities also offers a great range of activity and is valuable not only for the treatment of the patient but also for the economies it effects for the institution. It has been found that tearing and sorting rags and other waste material will hold the patients' attention and keep them happily engaged in work, especially mild grade imbeciles who have a tendency to be destructive and troublesome. This type of work can also be done by agitated and restless patients and also by those who are demented and deteriorated.

The department of occupational therapy at the Central State Hospital comprises two divisions, one for men and one for women, in charge of a head therapist and five assistants. The men make mattresses, brooms, doormats, all types of baskets and brushes, do weaving and woodworking and repair shoes and cane chairs. It is our intention to install a printing press in the near future. In the department for women the occupations are

sewing, mending, weaving, rug making, basketry, all kinds of fancy work including knitting and crocheting, stenciling and making dolls.

Well chosen amusements to stimulate patients into more normal mental activity are also necessary for this program. The play instinct, which exists in all of us, is too often suppressed, frequently with disastrous consequences, and many mental breakdowns can be attributed to the fact that the patients lead a too one-sided existence. Amusements that are provided for our patients are dances, theatrical performances, concerts and talking picture entertainments. We also have at our institution an extensive central station radio hookup, with loudspeakers distributed to sixty different wards and departments throughout the hospital. Radio programs are given our patients every day, especially during the evening for about an hour before bedtime. This hookup with a central station gives us an opportunity to select the type of entertainment best suited for our patients.

Talking picture entertainments are greatly enjoyed by our patients. Suitable pictures and comedies are presented, and weekly news reels keep the patients conversant with the happenings of the world. Notices of the entertainments are posted in advance, which generally stimulates interest and gives the patients the pleasure of anticipation.

Patients should be encouraged to do all they can to help themselves. They should be trained to look after their persons, especially their bodily functions, and to keep their clothing neatly arranged. They should make their own beds and keep their rooms tidy, and do things to add to the attractiveness of their wards. By various little touches women patients can give a homelike air to their surroundings, and many men can do likewise. It is often surprising what ingenuity and resourcefulness some of them evince in this respect, often making unique and artistic things from simple and unpromising material. Many patients give useful service to the institution in this way. We have a patient who prior to his illness did a considerable amount of decorative work in noted buildings throughout the country and he takes great pleasure in decorating our walls with beautiful designs and paintings.

Giving the Patients a Good Time

Checkers, dominoes, billiards and pool, cards and many other games are intelligently enlisted as amusements. Basket ball, croquet and tennis are also greatly enjoyed. Some of the patients have led such treadmill lives that their first experience with fun and a good time has come to them within the walls of a mental hospital. Fre-

quently patients who have returned home have written us later: "I miss very much the dances, the picture shows and the good times at the hospital." When the weather permits every patient who is able is encouraged to go outdoors. There we have a large dancing floor, and every afternoon concerts are given by either our hospital orchestra or by phonograph records.

I should like to state briefly some of the more pronounced manifestations of mental diseases and the particular type of diversional occupation that has been found most helpful in such cases.

The four principal types of mental diseases for which patients are committed to state institutions and which represent about 80 per cent of the admissions are manic-depressive psychosis, dementia praecox, paranoia and paranoid states and general paresis.

How to Help Excitable Patients

Manic-depressive is the name given to a mental disease that recurs in definite forms, periodically throughout the life of the individual, a typical case showing excited and depressed stages with normal periods between. These cases show little or no tendency to deterioration and the basic feature is an emotional disorder. In the maniacal type there is great excitability and loquacity; mental and physical restlessness are dominant, with rapidly changing emotions. These patients show rambling, disconnected conversation, rhyming, shouting, mischievousness, violence, disorder and destructiveness. In such cases it is desired to steady the individual, to decrease his motor restlessness, to train him to concentrate his attention, to interest him in some one thing. These patients are given sedative occupations in which there is little variety to distract and stimulate new lines of thought, yet which require concentration. Loom weaving, knitting, crocheting and basket weaving serve well as treatment in such cases.

In the depressed type the patient is dejected, undecided, inactive and slow in speech and thought. This picture is almost an antithesis to the previous condition and in such cases the occupation should be stimulating; consequently one is chosen that requires a minimum of stereotyped action. A new occupation that is unfamiliar to the patient will frequently prove of the greatest benefit because the necessity for concentration of attention will cause him to shift from the depressive delusional ideas that are worrying him.

Dementia praecox, meaning precocious dementia, is a form of psychosis affecting young people. The majority of these cases develop in early life, at the age of puberty or in the adolescent period. Persons with this disease present diverse symp-

toms, and space will permit the enumeration of but a few. Such patients as a rule have a defective heredity and furthermore have presented symptoms in early life that marked them as different from their fellows. A shut-in type of personality is noted, such as a tendency to keep to themselves, to be overreligious, to indulge in day-dreaming and immature philosophizing and to

all efforts made to awaken their interest. They may talk clearly and apprehend well their surroundings, or they may seem unconscious of their whereabouts or of the identity of their associations.

Since this class is so decidedly asocial, the type of occupation best suited for them is one that will have the effect of overcoming these tendencies.



These mental patients at work in the occupational therapy room are doing all sorts of handwork—embroidering, crocheting, stenciling, weaving rugs and making clothing.

manifest a lack of application and general inefficiency. Outbursts of excitement and violence of an impulsive, unreasoning character, silly attitudes, an often constrained and affected manner, expression of absurd ideas and a particular discrepancy in the emotions are observed. They fly at the other patients, break furniture, destroy clothing and throw their trays without any purpose. These patients are apathetic in the performance of their accustomed tasks, indifferent to the sorrows of their friends, and often are either irritably resistive or provokingly unreasonable to

Such patients should be given some form of work that can be carried on with others, as assisting in warping a loom. Group games are splendid for this purpose and social contacts such as dancing are valuable. Naturally all these occupations bring these patients into contact with reality and have an excellent effect in preventing mental deterioration. These patients are dissociated and with the treatment described their subconscious thoughts are brought into contact with the facts of external reality.

Paranoia or a paranoid condition is a chronic

progressive disease manifesting itself in early adult life and characterized by a well defined system of delusions of persecution. It is observed in persons who are bright and clever but who have always been considered queer. They show unusual association of ideas and see things in new and strange relations. It is often difficult for the laity to believe that patients with paranoia are mentally deranged because their consciousness remains clear, their behavior is correct as a rule, and they retain many of their mental faculties unimpaired. They often show remarkable ability in some one line and their powers of reasoning are excellent, but in regard to their own false beliefs reason is all astray because they reason from a false premise. They usually consider themselves as proficient and underrated geniuses. If unrestrained they may at times become dangerous if their delusional ideas are interfered with. When occupied such patients have less time to ruminate upon their delusions or to elaborate them into a system. They do well in lines of work requiring a certain degree of responsibility and when they are permitted to carry out something in which they are especially talented.

General paresis is a disease due to syphilis in which malarial therapy is now being applied with such satisfactory results. The Central State Hospital is one of the pioneers in this country in this form of treatment. Many of these patients are rehabilitated after their malarial treatment. The disease attacks persons in middle life, usually between the ages of thirty-five and forty-five. It is much more common in men than in women and is of a definite organic basis. The changes that take place in the brain and spinal cord are accompanied by progressive physical weakness as well as by progressive mental deterioration. Sometimes the physical symptoms appear first, sometimes the mental; again they occur simultaneously.

How Paresis Can Be Recognized

Some of the early symptoms recognized by the untrained observer are irregularity of the pupils, headaches, vertigo and epileptiform and apoplectiform convulsions. The mental symptoms are extremely varied and occur at different stages of the disease. At the beginning the patients may show dullness of comprehension that resembles stupidity. They become irritable, show sudden outbreaks of violence and though formerly skilled in such matters describe multitudinous extravagant and impracticable business ventures. The memory becomes seriously impaired, great deficiency in regard to time being an especially prominent symptom, particularly concerning recent events. The primary object in applying occupational therapy in

this group of cases is to inculcate better habits of thought and action. In some of these cases vocation of any type must be suspended during the period of the height of the disease. The occupation prescribed should in some measure be a substitute for the vocations so that there will be a return to the mental habits that characterize the normal life.

In closing I desire especially to emphasize again that in a diversional, recreational and amusement program there should always be close cooperation between the physician and those in charge of these diversified forms of therapy as an understanding of the particular ailment is necessary in each case. Also, in any scheme of organization, the necessity of making occupational therapy fit in with the other functions of the hospital must be constantly kept in mind. Occupational therapy is not to be regarded as a branch of work outside of the hospital itself, and cooperation of all branches of hospital work is necessary to bring about results in the task of rebuilding crippled minds.

Recent Developments in German Hospital Construction

A critical review of three new structural types of hospitals and sanatoriums that have recently been warmly received in architectural circles in Germany is presented by August Lommel, government architect, Wurzburg, Germany, in *Zeitschrift für das Gesamte Krankenhauswesen*.

The terrace type, a set-back type of construction, affords space for rest rooms, provides a large measure of sunlight for sick rooms and meets hygienic lighting demands. In construction, however, it presents a number of disadvantages. Above all it is expensive in that it requires auxiliary construction to support the separate stories.

The loggia type, recommended by Döcker, requires protective roofs for the loggias constructed in front, which makes a very long (or wide) structure.

The zigzag type, obtained by obliquely placed walls, results in a purposeful economy of space and makes possible a greater supply of air for the sick rooms through a narrowing of the halls. Compared with the terrace type it has greater hygienic, technical and economic advantages, especially with regard to the rest rooms in the open, placed in the corners of the single structures. However, in this case also the structure is expensive and is more suitable for the pampered requirements of a sanatorium than for a general hospital.

The Modern Hospital*

A Paper From the American Hospital Association Meeting

By WINFORD H. SMITH, M.D.

Director, Johns Hopkins Hospital, Baltimore

HOSPITALS are expensive institutions to operate, much more so than twenty years ago. Why? For the same reason that the cost of living is much higher. The character of hospital service is much more thorough, more efficient and more complex than formerly. The quarters provided have been made increasingly more elaborate, more comfortable and are provided with equipment for efficient service far beyond the provisions of earlier years. Anyone familiar with hospitals will concede these points without debate.

To be more specific, all articles of food and supplies of all kinds cost much more. The old system of hard, soft and liquid diets is no longer sufficient. We must have well organized dietetic departments which will provide diets of many kinds and varieties: cardiac, nephritic, diabetic, high calorie, low calorie, salt free, high protein, low protein, and so on. This involves not only a constantly greater variety of articles to be prepared, some unduly expensive, but also infinitely more labor in preparation and service.

The service is much more complex, as exemplified in the greater care with which patients are studied, the more numerous tests employed, such as x-ray, fluoroscopic, basal metabolism, blood chemistry, bacteriological, serological, physiological and biological. Treatment is also more complicated. More nursing service is required, larger resident staffs are needed, and likewise, more employees of all types. The planning of a hospital now provides smaller units for patients, the large open ward belongs to the past. This is necessary for the proper segregation of patients and for their greater comfort.

Meeting the Present Demands

Hospitals cannot, and should not, rely entirely upon student nurses for nursing service as was the case in the past, with daily duty covering twelve or fourteen hours. Shortening the working day for nurses, providing maids to do many of the household duties formerly assigned to the pupils and employing more graduates have in-

creased the cost of operation enormously, and unless I misinterpret the trend, the cost of nursing service will continue to increase, and it should, in justice to the patients and to the pupils in our training schools. The extensive developments of out-patient service, of social service, of follow-up, of efficient record departments, provision for hydrotherapy, electrotherapy, light therapy, radium therapy, mechanotherapy, are all factors that have entered into the increased cost of hospital operation. They have all resulted from the demands of the profession because of increased knowledge of disease and its treatment. No one should find fault with that.

Trained Executives Are Needed

In discussing the attitude of the public towards the numerous appeals for funds we must be sympathetic. We must go back to the basis upon which our hospital movement was conceived in order to explain the situation. In these days of superefficiency, every enterprise not yielding a profit is under question. The vast majority of our hospitals are small, providing less than 125 beds each. They are financially handicapped to begin with, and must do considerable free work. Where can such hospitals obtain competent, well trained business managers? They are not available for such small institutions. These hospitals, therefore, for the most part, must rely upon nurses as managers. Have they been taught business management? No more than the doctors. A more conscientious group of workers it would be hard to find, most of them are overworked, are trying to do effective work for which they have never been trained and are worried and harassed all the time. Sometime there will be a place where they can be trained specifically for such a job and then, perhaps, the job will be better done and they will command larger salaries and will worry less. But I am sure that no more sincere and conscientious effort will go into their work. Until that time comes, these hospitals and their communities will have to be content and would do well to appreciate what they have.

Governing boards should know what the job

*The first part of this article appeared in the November issue of THE MODERN HOSPITAL.

demands, should know what qualifications the persons possess whom they select. If they are unable to obtain those who are thoroughly trained for the job, they should help those whom they do select, not condemn them.

Are Trustees Guiltless?

Of course, changes are often needed, but those institutions that change managers every year or two, sometimes more frequently, have something wrong with them other than the superintendent. Sometimes it is due to members of the staff, sometimes to interfering trustees. Trustees have a right to interfere if the occasion warrants, but if they are intelligent they will realize that a superintendent should be given authority and support commensurate with the responsibility. Interference in such a manner as to destroy the authority and control of the superintendent is intolerable and inexcusably unbusinesslike. The attitude of many men who have made conspicuous successes in other lines of business toward hospital organization and administration is oftentimes amazing because of their lack of understanding of the problem and their unfairness in dealing with their executive representative.

The larger hospitals, able to pay for competent service, are, I believe, for the most part, well managed. You cannot compare a hospital with an industrial plant with its well paid skilled labor and closely knit organization, all operating to the end that a standardized product shall be turned out as economically as possible, all costs being absorbed and a percentage added for profit. Hospitals are not engaged in that type of business. The hospital industry is engaged in mending broken bodies, in removing diseased tissue, in taking a machine which is out of order and causing it to function smoothly once more, and to continue functioning. No two problems are quite the same because no two individuals are quite the same, either physically or mentally. Furthermore, while we can and do carry business methods into every phase of hospital operation, there is a point where standardized procedure and business methods stop. That is where the doctor begins to function in the professional care of patients. The doctor is successful because of his own individuality, his own method of doing the job and his own personality. He is individualistic in his methods and it would be a sad day when the attempt was made to standardize him, if it were successful. He might be more cooperative, however, in most institutions.

I referred to the basis upon which our hospital movement is founded. Has the growth of the hospital movement resulted from a carefully studied

plan based upon the needs of the population? Have the 7,000 hospitals been established according to a definite program of so many beds per 1,000 population, so many beds for this branch of medicine, so many for that, based upon the needs of the communities to be served? You know that such is not the case. Is the movement the result of well established policies of the state for serving its citizens, such as the principle underlying our public school system? It has been a haphazard development depending for the most part upon the medical profession and groups of interested laymen and is based largely upon the principle that it is the duty and privilege of persons of means to provide for their less fortunate neighbors. It is a beautiful principle and it has worked remarkably well, but is it sufficient to meet the requirements of the future?

The time has come when haphazard methods should be replaced by logical, sound methods based upon facts and sound principles.

To be more explicit, we have our boards of education which determine the number and type of schools needed, we have chambers of commerce, and commissions for industrial development to look after the commercial interests of cities. Is it not equally important that we have some machinery to consider the hospital requirements? To be sure, we have our state and city charity departments and health departments, but considering the handicaps under which such departments operate, we would none of us wish to place our hospitals under those agencies. I make the point that the time has come when there should be machinery of the state or the municipality which should concern itself with such questions as "Is another hospital needed, where, of what type, and how is it to be supported?" I do not mean that it shall run the hospitals. But such a commission should determine the needs of the community and should pass upon all new projects before they are undertaken and, so long as our hospitals must depend largely upon public support, should determine how much of the expense should be borne by the state or its political subdivisions and how much by private philanthropy.

How Community Hospitals Serve the Poor

Of all the hospitals in the United States 49 per cent are of the private or corporate type; 26 per cent are Federal, state or municipal in type; 25 per cent are private or commercial in type.¹

We know that, generally speaking, the states and counties concern themselves principally with hospitals for the tuberculous and the mentally ill. The cities provide some general hospital beds but

¹Publications of the Committee on the Cost of Medical Care.

not nearly enough. There are 5,600 community hospitals of which 4,300 are general hospitals. Generally speaking, excepting for the mentally ill, the tuberculous and the veterans in Federal hospitals, the care of the sick poor rests largely with the corporate or community hospitals. Is this statement well founded? A recent survey¹ of the hospitals in Philadelphia disclosed that 40 per cent of all patients in all hospitals were free, not including the city hospital. In New York City, the thirty general hospitals participating in the proceeds of the United Hospital Fund provided during the year 1929, 2,532,000 days of treatment, 44.2 per cent of which service was free.

These are fairly typical examples of the situation in the East and perhaps to a lesser degree in the West where more general hospital beds are owned and operated by the state and its subdivisions.

Who Pays for the Work?

Who pays for this free work? The survey in Philadelphia disclosed these figures for the fifty-two hospitals. Of the gross income available for operating these hospitals, excluding the Philadelphia General, a city institution, 58.7 per cent came from patients; 16.5 per cent come from endowments; 4.8 per cent came from cash contribution; 9.5 per cent came from federations; 7.4 per cent came from public support—city. In other words, these hospitals did 40 per cent free work and received from public funds 7.4 per cent of their total revenue and had a total deficit aggregating \$355,779.

I fancy this is quite typical of most cities, varying, perhaps, slightly up or down. And yet, in most states, if not all, real estate owned by these private hospitals for purposes of revenue and even the endowment funds, the income of which is used for the poor, are taxed by both state and city and at the same rates as any other real estate or securities which may be owned and used for the profits of business or of individuals.

It is worth while to analyze the foregoing figures further. About 43 per cent of the money available for operating these hospitals comes from sources other than payments of patients, and of this 43 per cent, only 7.4 per cent comes from public funds, so that about 35 per cent comes from endowments, cash contributions or the federations, which means that in one way or another this amount comes from private philanthropy. Here is a problem worthy of the consideration of trustees.

In the issue of the *New York Times* of September 25 there appeared a condensed statement relat-

ing to the financial difficulties of the hospitals of New York City. In this statement, which was in part a quotation from a letter sent to the board of estimates by a committee representing fifty-five hospitals, the following points were made: The private hospitals receive from the city an average of about \$2.09 a day for city charges. It costs these hospitals an average of \$4.54 a day. It costs the city \$4.56 a day in a group of its own hospitals. Ten of the larger hospitals suffered a deficit for the past year of \$1,275,000, due to their loss on recognized city patients. The entire group of hospitals lost on city cases the sum of \$2,503,858. In addition to the recognized city cases this group of hospitals gave 3,685,000 days of free care to other persons who could not pay, during the past three years. This group of hospitals, according to the report, is asking the city to increase the per capita per day allowance to \$3.30 and to provide for this work the sum of \$1,500,000 in the budget for 1932. In view of the facts, this certainly seems to be a reasonable request.

It is significant that at this time, with the long history of the development of American hospitals back of us, the total endowment fund of hospitals is estimated to be \$437,000,000² of which \$15,000,000 is for Governmental, \$3,000,000 for proprietary and \$419,000,000 for the community or nonprofit hospitals. This amount of endowment for the nonprofit hospitals is sufficient to endow 13,967 beds, of which there are 247,970 in this group of hospitals. The endowment is only sufficient, therefore, for 5.6 per cent of the beds. It is further significant, that of the 2,604 hospitals operating on the nonprofit basis, only 1,060 control any endowments, and of this number, 125 hospitals control 45 per cent of the total, and only thirty-one of these control more than \$2,000,000 each. Many hospitals in the United States do not receive endowment income in sufficient quantities to affect materially their financial policies. The point of all this is that the system is not sound, that with the increased cost of hospital operation, it is doubtful if the present system of support will prove adequate for the future financing of our hospitals.

More Equitable Distribution Is Needed

We certainly must not discourage private philanthropy, but would the system not be on a better basis if the burden were more equitably distributed by requiring the cities and states and counties to pay more nearly what it costs these hospitals for caring for the poor? It is stated that dependent persons are ill, on the average, nearly twice as often as persons with incomes considered

¹Sinai, Nathan, and Mills, Alden A., Committee on the Cost of Medical Care.

²Roem, C. Rufus, *The Public's Investment in Hospitals*.

adequate. The U. S. Children's Bureau,¹ in a study of 22,967 births, between the years of 1911 and 1916, in eight cities, found that in families, where the earnings of the father were above \$1,250, there were 59 deaths per 1,000; that the number of deaths of infants increased per 1,000 the lower the earnings of the father; for example, earnings \$850 to \$1,050, deaths 82.2; earnings \$650 to \$850, 107.5 deaths. Warner in "American Charities" gives illness as a cause of dependency in from 20.1 per cent to 43.7 per cent of dependent families. In view of these facts, would it not seem to be quite as important that we provide adequately from public funds for the care of the sick and for public health generally, as for education, for good roads, bridges and harbors, all at public expense? Certain it is that until this or some other method is found, the public must expect appeals either separately or through community chests. On the other hand, however, it is incumbent upon boards of trustees and their executives to put their houses in order. Extravagance and wasteful methods must be eliminated to the end that so far as is humanly possible, every dollar expended shall purchase a full dollar's worth of necessary service.

Too Many Unnecessary Hospitals Are Built

C. Rufus Rorem, writing under the title of "Economics of Hospital Care" states that "the pressing need in the field of hospital economy is for increased utilization of plant and equipment. This objective cannot be achieved by the hospital superintendent alone. It requires the cooperation of the general public. When a community allows a hospital to be built, it removes such invested funds from the control of existing hospitals, making it more difficult for superintendents to raise money to finance their own institutions. Every unnecessary investment in hospital plant and equipment limits the opportunities for existing hospitals to distribute the cost of their own institutions among a larger number of beneficiaries. No hospital should be constructed unless it is justified in terms of medical necessity or convenience. Expenditures for unnecessary plant and equipment are unfair to the general public which ultimately pays the bill, to hospital superintendents who manage the institution and to the medical profession.

"If hospital construction is to be restricted to the actual medical needs of a community, existing institutions must be coordinated in their medical services to the public. Coordination involves the apportionment of patients to available existing facilities in such a way as to utilize all local hospitals to the greatest capacity. Hospitals are not compet-

ing organizations but cooperative organizations engaged in the common task of caring for the medical needs of a group of citizens. Only by recognizing this fact can hospital superintendents be saved from unjust criticism in the administration of their institutions and fully discharge their responsibility for their use of the community's funds."

Are Charges Too High?

The public also protests against high charges in hospitals. In the thirty general hospitals in New York City, already referred to, the average daily per capita cost was \$6.79. Generally speaking, we may say that the average per capita for general hospitals is probably at least \$6 a day. If the cost of public wards was distinctly separated, still the cost would be considerably more than the average charge in the public ward, which is generally about \$3 a day, rarely more than \$3.50. That does not seem high. To be sure there are extras, but for ward patients these are usually reduced to a minimum or remitted.

Private room rates are much higher, ranging in the more expensive types of service, from \$7.50 to \$15 a day. The average per capita cost for private room service is without doubt higher than the lower priced rooms, probably about the same as the average price charged for rooms. As a business proposition, this is not excessive, when one considers that the public will cheerfully pay the same price at a hotel and get much less for the money. In the hospital one receives, in addition to his room, three meals a day, some nursing care, services of the resident staff, orderlies, and maids, ordinary medication and surgical dressings, etc. In determining the costs per day for private patients, it must be remembered that in most instances the buildings are given to the hospital and it is rare that hospitals include in operating costs any interest charge on capital invested or any allowance to be set aside for depreciation and obsolescence.

To be sure, the extras are heavy in most hospitals. I think the principle of charging extras on a cost basis would be sound if credits were likewise offered where standard service is not used, but this would entail a complicated system of accounts and even hotels do not do that. Generally speaking, I believe it would be better to eliminate all extras, if practicable. Many hospitals have gone part of the way in this, but I do not think we can go all the way, in fairness to the average patient, who would thus be obliged to pay for the fads and fancies of the rich or cranky individual whose demands either directly, or indirectly through his physician, are often excessive; nor can we always rely upon the physician to order only what is really necessary.

¹Bruno, Frank J., *Hospital Social Work*, Washington, D. C.

There is considerable criticism of the charges made by graduate nurses and of the need of employing special nurses in hospitals. I believe the charges of graduate nurses are not too high. They work long hours and must deal with situations that are most exacting, and sometimes most unpleasant. They have periods of unemployment, sometimes long periods. The private duty nurse earns, on the average, between \$1,200 and \$1,300 a year, and her years of active service are limited.

the average man has made no provision for illness. He resents illness anyway, and doubly resents the attendant expense. He has not denied himself in other respects however.

In the study of the cost of medical care in Philadelphia, conducted by Nathan Sinai and Alden B. Mills of the staff of the Committee on the Cost of Medical Care, the total bill for medical care was as shown in the accompanying table. It is based upon actual findings in part and the estimates are

WHAT THE PUBLIC SPENDS FOR MEDICAL CARE

Total cost			\$104,000,000
For physicians, dentists, nurses and cults			47,000,000
For physicians	\$27,000,000	Principal items of the above figures	
For dentists	13,000,000		
For osteopaths, chiropodists, midwives, etc.	3,000,000		
For patent medicines	obtained in drug stores		9,000,000
For prescriptions			7,340,000
For home remedies			3,692,000
For miscellaneous medical care sales			2,380,000
For hospitals, sanitariums, etc.			16,000,000
For indirect costs not included in operating costs of hospitals			7,206,000
Some other minor items are not given here.			

She is indispensable and her lot is hard, although satisfying from the point of service. By comparison with other lines of employment open to educated women, her earnings are too small rather than excessive.

As to the complaint against the need of employing special nurses in hospitals, a survey was made by a national committee covering 1,892 private patients who had specials and this showed that in 40 per cent of the cases the doctor urged a special on account of special care needed, in 33 per cent the family wanted a special, in 22 per cent the patient felt that the regular service was inadequate, in 3 per cent the hospital suggested one and in 2 per cent the reason was that their friends always had one. I believe, however, that hospitals should provide more adequate nursing service, but they cannot do it under the present system. One remedy, perhaps, is the development of group nursing. It is worthy of careful consideration.

The average duration of stay in the hospital, particularly for most surgical patients, is about half as long as was the case twenty-five years ago. This means that even if the hospital charge is double, the total hospital bill for that type of patient would be no greater than it was twenty-five years ago.

Considering all of these factors, I believe the charges are not out of line, although they seem high, particularly when the hospital bill, the doctor's bill and the special nursing fees are totaled.

Then, too, we must take into consideration that

computed on the basis of the data that were found.

The point is that the total cost of operating all of the hospitals is not the largest item by any means. The public spent for medical care sales in drug stores a total of \$22,986,000, of which over \$13,000,000 was for patent medicines and home remedies.

But it is of little use to criticize the public because it spends so much for home remedies and patent medicine. While it is true that if there was less high pressure salesmanship and if people spent less for radios, automobiles, electric refrigerators, electric washing machines and movies, they would have more money with which to meet doctors' bills and hospital bills, finding fault will not remedy the evils of the situation. We shall doubtless face these problems for a long time to come, but it is well to know the facts.

Many remedies have been suggested; I have already suggested some, and of others, among the most prominent are: (1) the formation of guilds for the purchase of medical and hospital service; (2) health insurance, compulsory or voluntary; (3) state medicine.

The guild idea may be a good one; it sounds attractive. But in our present state of social development, and particularly in the larger cities, I doubt if it would appeal to the class that presents the great hospital problem, the free and part-pay patients. The same applies to insurance, unless compulsory, and therein lie dangers of many varieties.

In Mr. Rorem's article to which I have already referred, he expresses the following conclusion: "Hospitalized illnesses, because of their irregularity and their relatively high costs, can be budgeted by the individual only through some type of insurance." He is speaking of those of moderate and small incomes.

As to state medicine, I am frank to say that I have been unable to see that it deserves our serious consideration unless and until all other methods fail.

I am convinced that the financial problem is one of the most pressing problems for the future of hospitals. I am convinced that hospitals cannot and should not be expected to do the work of the state and its political subdivisions at less than a fair cost, that the public must continue to support this work to a degree even greater than heretofore, that some form of insurance will need to be provided that will be accepted by all who need and can pay for it and that only by such methods coupled with efficient management will the financial future of worthy hospitals be assured. In this connection it is interesting to note that already a few small hospitals have instituted an insurance plan that guarantees hospital care.

In the very multiplicity of agencies and individuals concerned in the provision of medical care lies perhaps an outstanding weakness in our present system. It may well be that from the medical standpoint, the greatest need is not for more hospital beds, not for more doctors or more public health activities, but for an agency to organize and coordinate all medical facilities so that each may render its greatest usefulness to the public and may cooperate most effectively with all others in best serving the interests of those concerned in purchasing and paying for medical care.

Why the Physician Should Know the Patient's Social History

That the conscientious physician will take into consideration the social history as well as the medical history of his patient is the subject of a letter from Dr. E. M. Bluestone, director, Montefiore Hospital, New York City, to the *Journal of the American Medical Association* and which appears in the October 17 issue of that magazine.

Doctor Bluestone's letter, in part, follows:

"The clinical biography of ward patients in hospitals is normally constituted of three parts: (a) the purely medical and nursing bedside record which is an historical outline in syllogistic order of the progress of the malady from the pathological point of view, in accordance with the observations

of the patient and those who take care of him; (b) the laboratory record which provides clues to the solution of the problem which only the exact sciences can furnish, and (c) the social record which provides the social background for the scientific picture and tells of factors which do not lend themselves to exact scientific treatment, but which in a real way influence the origin, clinical course and outcome of the disease. That these three essential parts of the patient's record overlap and may not be considered independently by the medical scientist upon whom the solution of the medical problem depends, or for that matter by the social worker, is one of the great discoveries (or is it a rediscovery?) of modern medicine. In actual hospital practice, however, does the physician inform himself (and others) of social factors influencing the patient's illness as an aid to the exercise of his diagnostic and therapeutic skill? Is it generally recognized that social treatment and medical treatment are interdependent?

Coordinating Social and Medical Histories

"In how many hospitals are the social and medical histories kept together and brought to the notice of the visiting and resident medical staff when the patient is submitted to them by the governing authorities of the hospital (and by the community) for study? How close is the cooperation between physician and social worker in the management of ward cases? In the operating room, as the patient in his artificially peaceful slumber is wheeled in, unconscious, ready for the specialist to demonstrate his mechanical skill, the doctor will read a summary of the medical history and present it in the form of a problem in pure science. But how often, if ever, does he read out those social facts which had so much to do with the plight of the patient. 'Gentlemen,' one can almost hear him saying to the assembled students in a sympathetic voice that indicates concern, 'this is an unfortunate working man of middle age, the father of five dependent young children whose mother has been broken down by the illness of the patient. We hope that we are doing the right thing by operating in this instance. If he does not survive this operation or if this operation should prove to be unsuccessful. . . .' Among other things the reading of social histories in this matter might have the effect of increased consultation service for the patient, in the anxiety of the specialist to divide and share the responsibility for a surgical operation which, under any circumstances, should always be a matter of grave concern to everyone and not only to the patient. Other and equally obvious benefits might come from deeper consideration of social factors."

A Dental Clinic for Children That Is a Model in Designing

By KENDALL, TAYLOR & COMPANY

Architects, Boston

NO DEVELOPMENT in recent years has been of so much interest to dentists and medical men in New England as the Joseph Samuels Dental Clinic for Children, which was dedicated as an additional department of the Rhode Island Hospital, Providence, R. I., last March.

Simple dedicatory exercises were held, presided over by Harris H. Bucklin, vice-president of the Rhode Island Hospital, at which a large and distinguished company of dental and medical men, many state and city officials and a large number of leading Rhode Island citizens gathered to pay

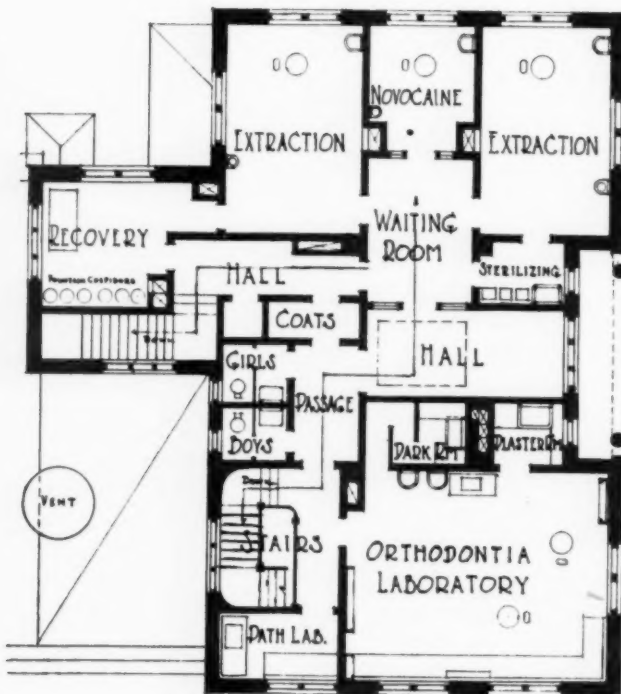
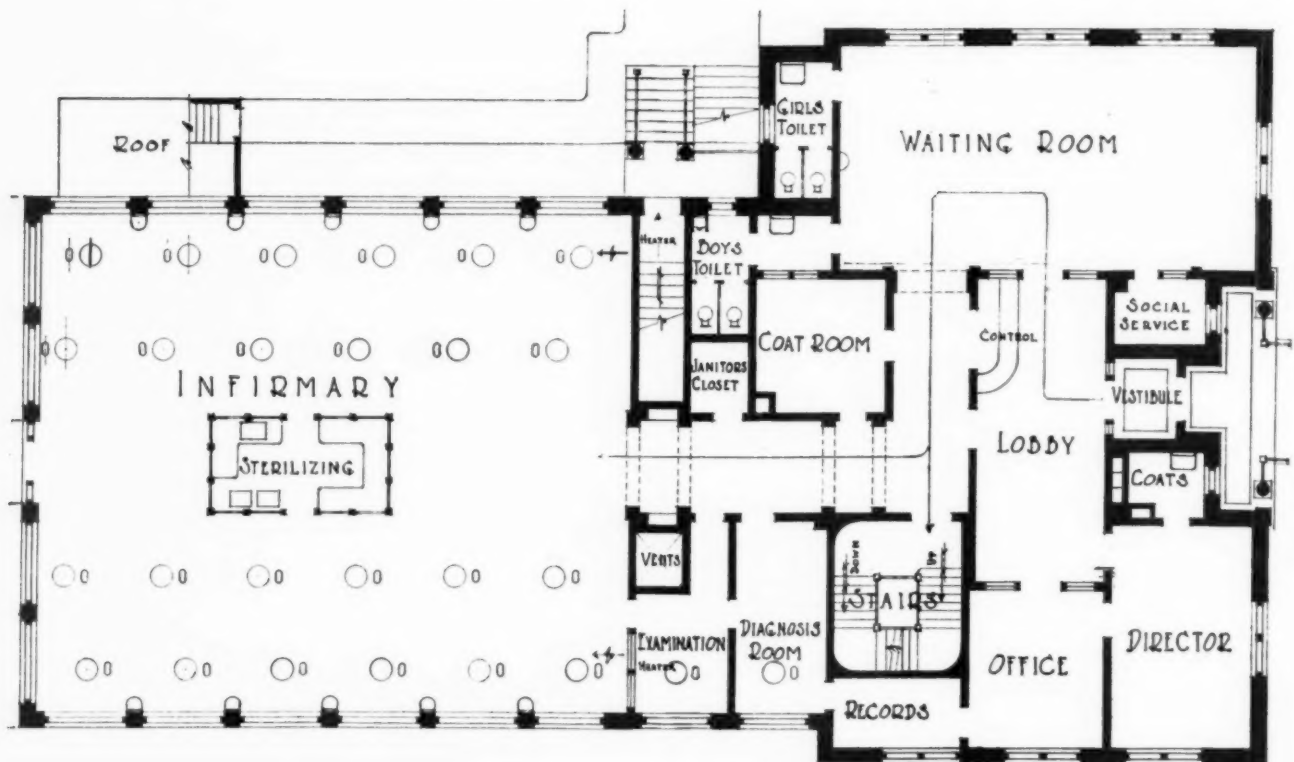
tribute to Col. Joseph Samuels, the donor, and to inspect the new building and equipment.

Colonel Samuels' gift of \$300,000 for this dental clinic for the city's poor children and his plans for the further endowment of the new hospital department are deeply appreciated by the authorities of the Rhode Island Hospital and will be followed undoubtedly by similar gifts in other sections of the country.

Dental and medical men are enthusiastic over the new clinic. It is the first new, modern clinic of its kind to be made an organic part of a large general hospital, and it will occupy a distinctive



The main entrance to the Joseph Samuels Dental Clinic for Children has a Palladian motif and limestone trim.



A large part of the first floor, shown in the upper plan, is given over to the treatment room, which is flooded with light from the large windows that take up most of the space on three sides. The smaller plan is of the second floor, which is devoted to special dental work, such as orthodontia, extraction, x-ray and laboratory facilities.

position in medical and dental history by providing the opportunity for active cooperation between the dental and the medical staffs. There is nothing about the plan, however, that would prevent its use for similar clinics, which might well be built anywhere as independent institutions.

While the opening of the Joseph Samuels Dental Clinic means that now it is only necessary to make the proper application to obtain for poor children an examination and the adequate care and treatment of their teeth, the hospital will have social workers investigate each application so that only those in needy circumstances will be admitted. All others must go to dentists in the city for treatment, for the new clinic does not intend to interfere in any way with the legitimate business of dentists in cases where parents can afford to pay charges made by the profession. It is expected that recent graduates of dental colleges will be obtained to serve in this clinic, just as at present young medical school graduates serve the hospital as interns. These dental interns will work under the direction of experienced dentists for a definite period before going out into active practice.

The Joseph Samuels Dental Clinic will be conducted, as are the other departments of the Rhode Island Hospital, under the direction of its superintendent. Actual operation of the clinic will be carried on by Dr. Ernest A. Charbonnel, who was one of those primarily responsible for interesting Colonel Samuels in the humanitarian scope of dentistry.

Those charged with the responsibility of planning, erecting and equipping the clinic made a close study of the only two independent dental infirmaries of a similar nature in this country, for the purpose of incorporating in the new clinic their best and most useful features.

This clinic building, harmonizing with the other Rhode Island Hospital structures, faces and has its main entrance on Hospital Street, at its junction with Eddy Street. It has a large Palladian motif entrance with limestone trimmings. Red brick forms the body of the building. The location is close to the Eddy Street main entrance to the hospital grounds and is north of the out-patient buildings, to which it is connected by a covered corridor, so that any child may be referred easily to the out-patient department for examination and treatment of conditions other than dental.

The outside dimensions of the Joseph Samuels Dental Clinic building are 62 by 90 feet, with two stories above the ground in front, an extension in the rear where the treatment room has been given an unusually high arched ceiling, and a well lighted basement floor.

The rooms in the new building are splendidly

lighted and are provided with all that is up-to-date in the way of electric fixtures and plumbing. All interior materials are fireproof and designed to be easily cleaned.

On the first floor of the Samuels Dental Clinic for Children are a director's office, a secretary's office, a record room, a lobby in which the control desk is located, a social service room, a large waiting room of unusual design, lavatories, a check room in which children's hats and coats are placed. A corridor leads to two fully equipped examination rooms, one for x-ray diagnostic use and one for medical examination. In the large treatment (or operating) room are six dental chairs and units that face south and six that face north. Provisions have been made for twelve more chairs when they are needed.

Every precaution has been provided to prevent any unfavorable impression on the small patients. After they have removed their coats and wraps, the children, supervised by adult attendants, are ushered into a large waiting room which is distinctively attractive. The room is designed to imitate a terrace of a house surrounded by broad grounds and charming vistas, while the ceiling



A waiting room that makes waiting a pleasure. An outdoor effect has been achieved by scenic walls, cages containing real canaries and cleverly designed woodwork.

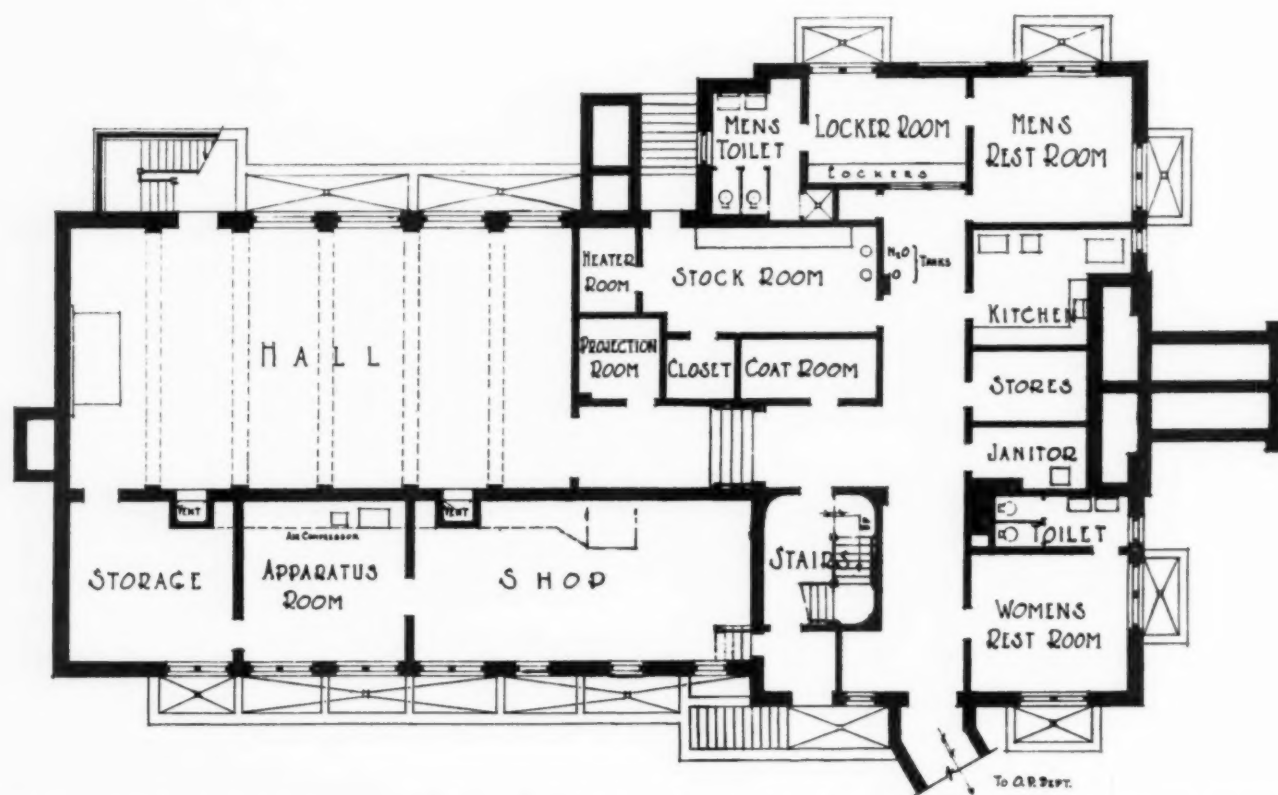
overhead reproduces a cloud dotted blue summer sky. On the terrace columns are hung cages containing singing canary birds, and painted on the columns are climbing vines, which extend upward to lattice work, where they become blooming wistaria and other varieties of bright colored flowers that transform the waiting room into a fairylike garden scene. Typical Rhode Island landscape and marine views have been painted upon the walls, and the effectiveness of the illusion they give is accentuated by an imitation red brick wall running around the room, broken with real wooden gates, painted white. These gates keep the children away from the heating elements that are concealed behind them.

The treatment room, infirmary or operating room, as it is designated by various visitors, occupies the entire rear of the first floor and is flooded with daylight from the large windows that take up most of the space on three sides of the room. This room appears even larger than it actually is, however, because of its high arched ceiling, and because all of the present twelve dental chairs and individual lavatories, which may later on be increased to twenty-four if desired, are in one large room, instead of in separate small rooms. The room is lighted by indirect lighting and has a sound absorbing ceiling in plaster. In this so-called treatment room are the latest types of dental chairs and units. A compact supply section and sterilizing

station are in the center of the room. The floors are of rubber, with terrazzo under the chairs, and the chairs and units are of mahogany. The walls of this and all other rooms in the Joseph Samuels Dental Clinic are of light cream colored, machine made, terra cotta block with a smooth surface which, because it is easily washed, ensures cleanliness with a minimum amount of labor.

On the second floor are a small waiting room, a check room, a soundproof room for use in the administration of local and general anesthetics, two soundproof rooms in which teeth are extracted, a recovery room, a special technique and orthodontic laboratory, a plaster room, an x-ray development room and a small pathological laboratory where dentists may carry on special research work.

There is also a separate rear stairway, so that children leaving the extraction rooms may do so without passing others who are waiting. Any room in which a child might cry is provided with soundproof doors and sound absorbing ceilings. The psychology of the separate stairway is to forestall unnecessary timidity in other children who might be waiting their turn for the extraction of teeth and who might quite likely be frightened by suggestion. Accordingly, it has been planned that children who have had teeth extracted shall pass down the rear stairway, get their coats without seeing anyone but the attendants and then go out by a side exit. The plan shows this arrangement.



On the ground floor is a large assembly hall where the dental profession of the state may hold meetings and lectures.



In this view of the south side of the treatment room we see five of the six complete dental units. The same arrangement is duplicated at the north end.

On the ground floor or basement of the clinic, the dental profession of the state is provided with an assembly hall capable of seating 150 or more persons where meetings and lectures with moving pictures may be held. This lecture hall has a separate entrance so that it can be separated from the rest of the building, and thus not interfere or conflict with the other uses to which the building is devoted.

In the basement also are lockers and dressing rooms for the dentists working in the clinic, space for a lunchroom, storage facilities and separate rest rooms for men and women workers.

All the laboratory facilities in the clinic building are available to practicing dentists and also to those who are taking extension courses at Brown University.

Doctor Charbonnel, director in charge of the new clinic, is of the opinion that it will exert a powerful influence in combating the enormous increase in decay of teeth of poor children, and that a new cooperation will now be possible between the public schools and dentists.

Dr. Albert L. Midgley, chairman of the extension committee, Rhode Island Dental Society, is equally optimistic concerning the good he believes the Joseph Samuels Dental Clinic for Children

may be expected to accomplish in the community. Doctor Midgley says that with the facilities now available to protect and keep in good condition the mouths and teeth of poor children through frequent inspection and care, there should be little excuse for their having pulpless teeth or suffering from the numerous ailments caused by poor teeth.

It is also felt that here is a new medium that will be used extensively to bring postgraduate instruction and knowledge to local practitioners, and that educationally it will be of material benefit to a large number of dentists in Rhode Island.

From the foregoing description it may be readily apparent that this clinic provides the answer to what has long been a need of the dental profession in Rhode Island, since it places at the disposal of a large number of dentists a splendid, centrally located meeting place in which their problems may be discussed and considered to mutual advantage. At the same time it is the opinion of Providence dentists that the new clinic removes a handicap under which they have always labored in endeavoring to improve the health of poor children and that they have acquired now the powerful assistance of the medical profession as well as the guidance of one of the state's oldest and most successful institutions, the Rhode Island Hospital.

Progressive Medicine as It Is Practiced in California

By MICHAEL M. DAVIS, Ph.D.

Director for Medical Services, Julius Rosenwald Fund, Chicago

DURING a visit in the late spring to San Francisco and Los Angeles, I had the opportunity to meet individually and in groups a considerable number of physicians. From officials of medical societies, from members of university medical faculties, from practitioners in various branches, I received an almost uniform impression that they and the medical profession in California as a whole are looking forward with open minds to impending changes in the practice of medicine and are endeavoring to make constructive plans that will enable physicians to take the leadership in these changes.

One outstanding problem faced by the medical profession in California is the recent though growing prevalence of the system of paying for medical service on an annual basis. This is regarded as a form of voluntary sickness insurance. Certain large industrial enterprises, notably the Southern Pacific Railway Company, have established systems of medical service for their employees, largely supported by regular weekly or monthly contributions from the beneficiaries, and it is probably because of the prominence and success of these industrial enterprises in sickness insurance that the idea of obtaining medical service in return for an agreed annual payment has become familiar to the population at large. Aside from examples in railway, mining and public utility corporations, the tendency is spreading in other industries, the California and Hawaiian Sugar Corporation and the General Controlling Corporation being among the large companies that are this year establishing similar services.

Paying on a Monthly Basis

An interesting example in which the workers themselves took the initiative exists in Los Angeles, where more than two thousand of the employees of Los Angeles County have contracted with the Ross-Loos Private Group Clinic to supply complete medical service in return for a payment of \$2 a month from each employee. The Ross-Loos Clinic has been in operation for a number of years as a private partnership of two physicians

who, as in many other group clinics, have added to their staff a number of other doctors representing general medical practice as well as specialties. The arrangement with the county employees is, of course, only a part of the practice of the clinic. In return for the \$24 a year, hospital care for acute illnesses, care for ambulatory conditions at the clinic and home visits when necessary are supplied. Dependents of employees may receive service for additional charges, which, however, are at specified and reduced rates.

What Employees Think of the Plan

The president of the county employees' association told me that the plan was highly satisfactory from the standpoint of the employees. They were greatly pleased with the service rendered. Many of their members, receiving as they do small though regular salaries, could now obtain medical care that formerly was quite beyond their means. A committee of employees acts as a mediating body to deal with questions arising between the medical group and the beneficiaries. It also receives and endeavors to adjust complaints. Other groups of public employees, during the time of my visit in Los Angeles, were seeking to make similar arrangements for annual payment service.

That this idea has not only become prevalent among the employees and officers of large establishments is shown by the existence of numerous organizations, usually known as "hospital and health associations" or by some similar title, which "sell medical service" to individuals for \$1.50 to \$2.50 a month. The law in California, or its present interpretation, appears to regard such arrangements as service contracts and not as insurance. Hence, these hospital and health associations are not under the supervision of the state insurance department and do not have to comply with regulations concerning financial stability, such as would safeguard regular insurance enterprises. The consequences seem to have been unfortunate for many of those who have purchased such services. Contracts, in some instances at least, seem to be so drawn as to carry a good many

exceptions in fine print so that what the purchaser thinks he is going to get will not be forthcoming when he asks for certain medical care during his illness.

Some of these organizations, however, have been in existence for ten years or more, which means that they must have given satisfactory service to their clients. On the other hand, there are fly-by-night concerns that make money on selling insurance rather than by giving service. But the striking thing is that a large section of the public is so imbued with the idea of buying medical service in this way that such "insurance" is salable. These associations engage one or more individual physicians to supply the medical care, an arrangement that tends toward buying such service at a cheap rate and of poor quality.

How One Association Functions

Some of these associations are indeed owned and operated by physicians, others apparently by laymen. One was found which, while it was nominally a lay corporation, was actually in the control of three physicians who owned the majority of the stock, the two laymen concerned being mere dummies. This organization presented the entertaining spectacle of the controlling physicians making contracts in their corporate capacity with themselves in their individual capacity as practitioners, to provide medical service to clients of the organization. Other physicians were also employed. Of course the physicians in every case retained their legal responsibility as practitioners for the medical care of their cases. Here is a nice question for the legal mind: Is such an organization a corporation practicing medicine?

The constructive efforts of the medical profession of California are illustrated by the recently published plan of the Los Angeles County Medical Society, under which the society has agreed with the employees of the Metropolitan Water District of Los Angeles, in return for a fixed monthly payment from each member, to provide home or office care at agreed rates on a fixed published schedule, which is specified also for laboratory service, surgical operations and for hospital care. The monthly payment for each employee is to be \$1.50 to start with, with the expectation that this may have to be revised as the result of experience. The individual employee has the free choice of physicians among all the members of the medical society, but no individual physician is obligated to give service under these conditions unless he chooses to do so.

In an editorial in the June 18, 1931, bulletin of the society, the following comment is made on this plan:

"The working out of the basis of the cooperation with the Metropolitan Water District has given an opportunity to put into effect a trial of the practice of medicine on a group purchase plan basis, which allows all members of the Los Angeles County Medical Association to participate, instead of limiting the work to a small group. In the conferences between the special committee handling this matter and the representatives of the Metropolitan Water District, it has been distinctly understood that the plan as printed in this issue of the bulletin is an experimental one, and it is hoped that every member of the association will give whole-hearted cooperation in this effort to establish definite facts, so that we may avail ourselves of the accumulated knowledge for future contacts with various public and private organizations employing large groups of persons with a low earning capacity. It is understood that each member will give the best of his services and refrain from building up the fees unnecessarily, and in the event that proper treatment cannot be given on the basis of the fee schedule as arranged, adjustments will be made by the Metropolitan Water District and this committee.

"After a sufficient time has elapsed to have proved or disproved the correctness of this plan, a committee representative of the association will act as arbitrator in cases where inequity is thought to exist between the doctor, the patient and the Metropolitan Water District. This entire plan was read to the council at its last meeting and was unanimously approved and a vote of appreciation given to the committee for the manner in which this contract has been worked out. It is the hope of the council and of your officers that the membership as a whole will reciprocate with the Metropolitan Water District, as this appears to be a step forward in the solution of the much discussed problem of state medicine."

Combating the Sects and Healers

California physicians face one difficulty more than those of any other state—the sects and the healers. If one opens the classified telephone directory in Los Angeles, one finds something that I have seen in no other city in the United States. Under the heading, "Physicians and Surgeons," there appear as subheadings, "chiropractic physicians," "osteopathic physicians," "naturopathic physicians," each in alphabetical order, and, (save the mark!) "medical doctors" under which heading the licensed practitioners with the degree of M.D. are found. One of the deans of the profession in southern California said to me, "We have had no success whatever in combating the sectarian practitioners and the healers. When we

have fought them, the citizens of the state have backed them up, even by referendum. They have sometimes capitalized our opposition in order to win support for themselves as under dogs. How can we deal with this problem?"

The constructive method of dealing with it has already been illustrated by the attempt to supply service of a quality that will ensure satisfactory results through a system and amount of payment that will satisfy the client financially. It is significant that the California State Medical Society is grappling with this problem constructively, illustrating in a larger way what the county society is attempting. Through a committee officially appointed by the state society, a plan is being worked out for demonstrating how medical services can be supplied to a considerable area, such as a county, at an agreed annual sum per person, and with a specified schedule of rates for the various forms of medical service. As an officer of the society said to me, "The citizens of California are demanding something. If we of the medical profession do not meet the demand, lay groups will take away from us the power of initiative."

Traffic Noise in Hospital Zones a Menace to Patients

Noises in the vicinity of 80 per cent of the hospitals of New York City are harmful enough to retard appreciably the recovery of patients, according to a report prepared for the Noise Abatement Commission of New York City, and made public recently by Edward Fisher Brown, director of the commission.

"That this situation is grave," it is stated in the report, "may be seen from the fact that in almost half the hospitals studied the noise conditions were found to have a really serious effect on the health of the patients. In the other hospitals the effect was described as either 'important' or 'annoying.'"

The survey revealed that noise made by traffic and especially by trucks was the principal cause of injury to the sick. Additional information obtained from the report, which was prepared by James Flexner, executive secretary of the commission, is as follows:

It is recommended that the law requiring silence on hospital streets should put a complete stop to traffic noise and should be used by the police in arresting unnecessarily noisy trucks passing through these streets. Many hospital superintendents requested that trucking be routed away from

streets adjoining their institutions. New signs demanding silence also were requested. It is recommended further that patrolmen be stationed at hospitals to see that children playing near by are sent to playgrounds. Fire apparatus should avoid hospital streets as much as possible. Noise made by animals should be abated by the health department under the sanitary code, while doormen's whistles and peddlers should be stopped under the hospital street ordinance. Other noises complained of should be similarly reduced.

In conducting the survey, a group of questions was drawn up and sent to the superintendents of all hospitals in the greater city. Seventy-nine replies were received, 42 from Manhattan, 24 from Brooklyn, 8 from the Bronx and 5 from hospitals in Queens.

The first question was "Does any noise condition or conditions in the vicinity of your hospital retard appreciably the recovery of your patients?" Of the 69 superintendents answering this question, 55 replied in the affirmative and only 14 in the negative. In Manhattan 30 superintendents said "yes" and 6, "no"; in Brooklyn 20 said "yes" and 3, "no"; in the Bronx 3 said "yes" and 3, "no," and in Queens 2 said "yes" and 2, "no."

The second question asked whether the effect on the patients was "serious, important or annoying." Thirty-four superintendents considered the noise so grave a menace that it seriously injured the patients; 20 thought it important; 17 annoying, and 7 found that the noise around their hospitals did not affect the patients at all.

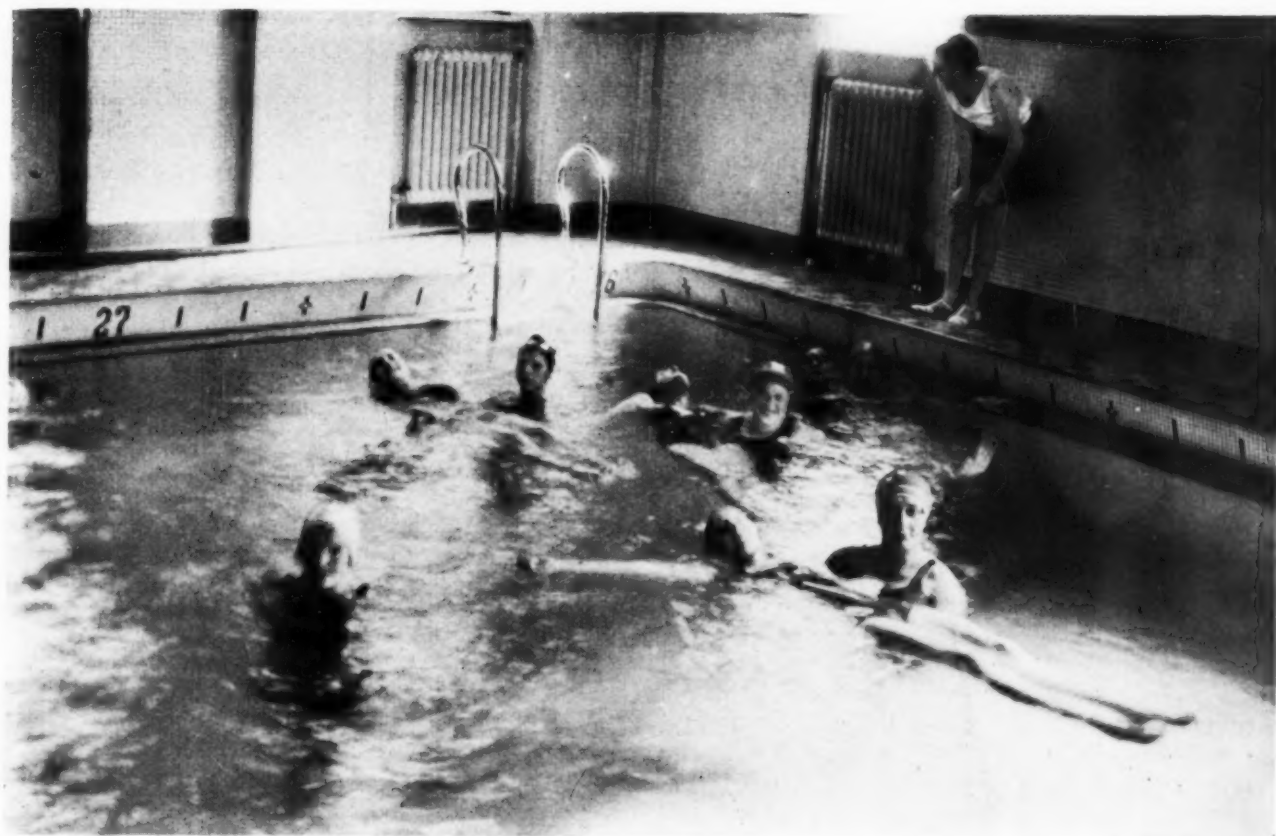
A Handbook on Iowa Laws That Relate to the Indigent

The University of Iowa has recently published a handbook for county officials, physicians, social workers and other clientele of the university hospitals in which are presented in brief and comprehensive form state laws relating to the medical and surgical care of indigent persons.

The foreword says: "This pamphlet has been designed with the hope that prospective patients, physicians, county officials, social workers and other interested individuals may become more familiar with the application and the factors involved in administering the law relating to the medical and surgical treatment of indigent persons.

"An understanding and a knowledge of these facts on the part of all will prove mutually advantageous to the university hospitals and their clientele."

There is a complete index at the end.



Organized Recreation as an Aid in the Nurse's Education

By M. E. PILLSBURY

Director of Professional Activities, and

VIDEL HUDLER, B.S.

Social Director, Jewish Hospital, Brooklyn, N. Y.

THE chief interest of anyone connected with a hospital is the patient. The care of the patient lies directly in the hands of the nurses and doctors and indirectly in the hands of the administrative staff of the hospital. The patient is more dependent upon the nurses for care and comfort than upon any other division of the hospital personnel.

When the question, "Do you prefer students to graduates for your work?" was asked of a large number of superintendents of nurses, 76 per cent answered "yes." This would naturally indicate that there is something wrong with the system of educating student nurses, since when they have completed their training, they become less desirable than when they were students. Some of the reasons given for this preference were that graduates come and go with great rapidity and that they

are difficult to manage and are not dependable. In any business organization a rapid turnover of employees would be questioned and an efficiency expert would soon be employed to discover what was wrong with the organization. But in a hospital, the fault is all too quickly laid upon the employees themselves—"it is the graduates." The system of preparing these graduates, the system of placing them and the attitude of the employer toward them are apparently not questioned.

The registered graduate nurse is the student whom some school has signified as having satisfactorily completed her course of training and upon whom some state board of nurse examiners has put its stamp of approval in the term "R.N." For her future conduct, for her knowledge of the art and science of nursing, some school should hold itself responsible. But does it? All too often it assumes

only a "paper responsibility." Some effort is made it is true by alumnae associations to keep in touch with the graduates but more for the purpose of getting dues than for advising and encouraging the members. I have heard a superintendent of nurses say that a certain number of graduates in each class are deadwood but that this must be expected. And yet this deadwood is turned out for some trusting member of society to engage to care for a beloved member of his family. No wonder that nurses are eyed with a skeptical lift of the brow.

Are We Training Our Nurses Properly?

It is upon the preparation of graduates that hospital heads should concentrate. How carefully are we weeding out poor material during the preliminary or probationary term? How do we guard their health and preserve their strength during the strenuous period of training? What training for life are we giving these young students?

How thoughtfully do we consider and with what justice and mercy do we deal with their shortcomings? How far do we look into the future and picture the present student as a graduate and representative of the school? Do we consider our student nurses as cheap labor whom, when they graduate, we shall replace with other students? Graduate nurses are as the schools make them. They could not graduate if the school did not permit it. It is therefore the duty of the schools to adopt measures and to insist upon means for converting the present students into acceptable graduate nurses. In brief, the outstanding measures to be taken may be listed as follows: careful selection of students; a preliminary term of four to six months, with hospital experience delayed until the last month; ample provision for supervised recreation and play through the entire course of training; health measures carried out systematically and directed by a health supervisor; a preventorium where students with minor illnesses are cared for; teachers who know how to meet the problems of young persons; practical experience planned to teach the young student and not to reduce expense.

Almost all graduates have skill in nursing. It is not their nursing that is at fault, it is their approach to the patient, their lack of adaptability and poise, that is, lack of knowledge of human relationships. The description that follows of the training of student nurses at the Jewish Hospital, Brooklyn, N. Y., gives some idea how social preparation gives the graduates an understanding of human relationships.

The main purposes of the work of the social director in the Jewish Hospital school of nursing are to take the responsibility for the general behavior of all students and to instruct them in

activities that will have a carry-over value and, indirectly, to guide them when they seek diversions outside the hospital.

The residence hall is governed by a house committee composed of an equal number of graduates and students. The social director is chairman. This committee meets every month, makes all rules concerning the residence hall and decides on the privileges to be accorded each student class.

For the convenience of the nurse in charge of the residence hall at night, students sign out on leaving the building the day they expect to take late leave. If they do not take it, it is not registered in the book. If a student returns at a later hour than 12:30, she writes the social director a note explaining the cause of delay.

Because of the honor system and the many privileges allowed, the students give practically no trouble about late leaves. Late leaves are never withheld as punishment for poor nursing. If a student is ill and is taken off duty, she must make her request to the office of the superintendent of nurses for her first late leave after she returns to work. This is required because that office has a more accurate way of checking up on a student's work in the hospital and on her health in general than the social director, who sees her only when she is not in the hospital.

Rules That Guide the Students

Any student who is too conspicuous in her dress is called in conference with the social director and is advised as to the proper clothes to wear.

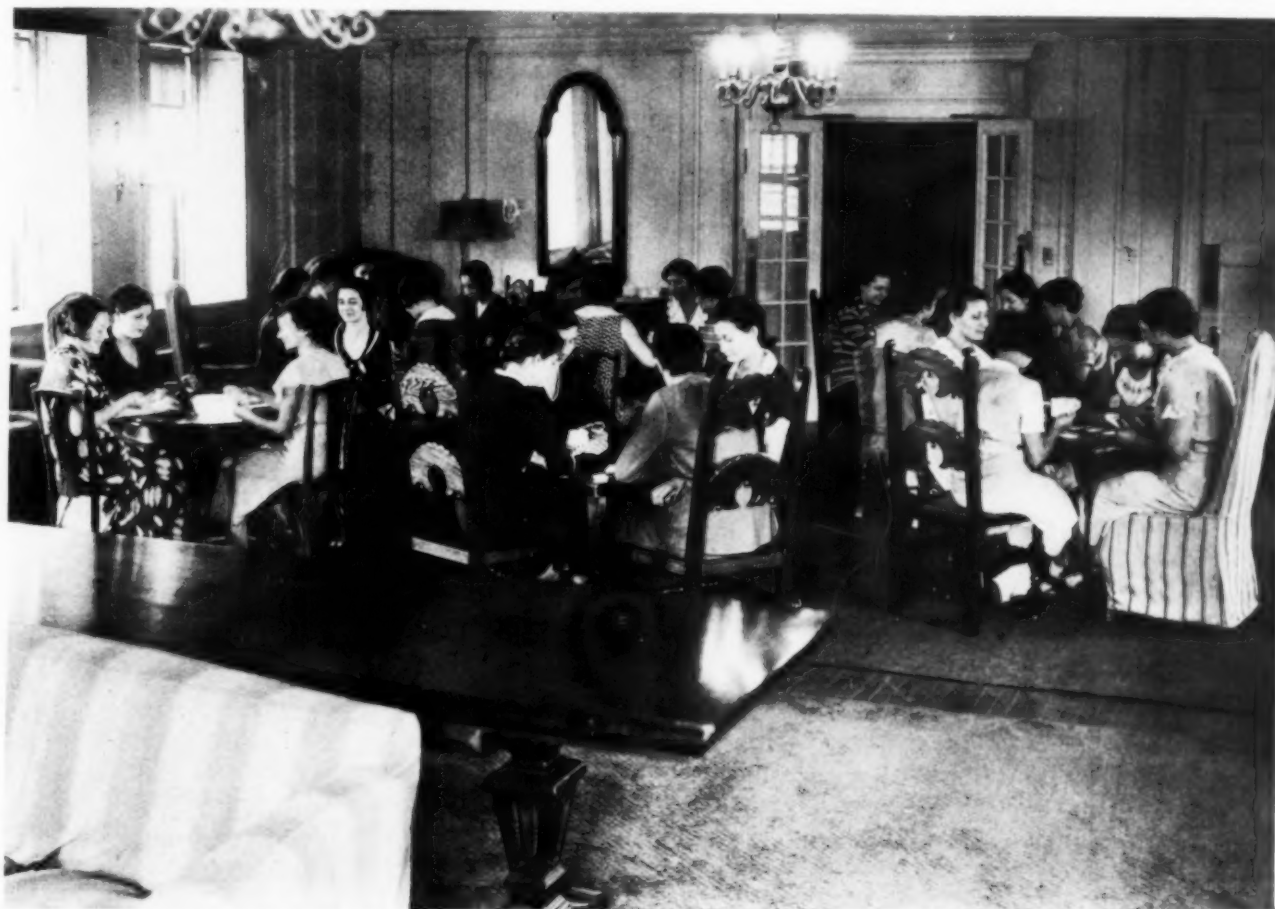
Quiet hours are observed in the residence hall from 9 a.m. to 4 p.m. and after 10:30 p.m. Students are on their honor and no regular rounds are made. A member of the house committee lives on each floor and anything unusual is investigated by her. The representatives of the house committee have full authority to discuss any matter concerning behavior in the residence hall at the time of the occurrence or to report it to the social director. The piano on the main floor may be used at any time up to 10 p.m. Graduates and students may have guests at meals and overnight.

After a number of years of experimenting to find a program of activities that would reach the largest number of nurses during the week, the following schedule was adopted and has been in practice here for two winters, with satisfactory results. During the four months' preliminary course we have inter-curricular classes in swimming, group singing, personal hygiene, bridge and current events. Records of the students' progress are kept and sometimes special lessons are given. During the junior, intermediate and senior terms one hour a week is devoted to each section during

the school hours. All other activities are extra-curricular and a program of selective interests is offered. Each class has an evening for its activities. The head nurses arrange schedules of afternoons off to fit in with the program of recreation, that is, the group having activities on Tuesday are not on afternoon duty that day. The choice of an activity is put to a vote and the hour, eight to nine p.m., is used for the one although from nine to ten is usually given to swimming. In this school night

minutes, tread water, make a surface dive, employ the side stroke in form and know how to resuscitate a person who has nearly drowned. In the third group the tests consist of the single overarm stroke, the crawl and trudgeon (in form), a front dive in form and life saving.

As each student passes her test, the empty square on the chart corresponding to that test after her name is filled in. Thus, when a student has completely passed her first (or red cap) test,



The bridge club, an outgrowth of class instruction in the game, is a valuable part of the nurses' social training.

duty starts at 9:30, so that the night nurse may go to the early evening activity. The superintendent of nurses gauges the students' interest in things other than nursing by the interest they manifest in these social activities.

The program followed during the year includes swimming, group singing, bridge, dramatics, instruction in ukulele playing, volley ball and attendance at evening social events.

Swimming charts are used to show the progress of each student in the school. Each class has its own chart. All have the same three groups of tests. In the first group the students must learn to jump in feet first, dive in head first, float ten seconds, swim twelve yards and recover an object. In the second tests they must be able to swim for five

the spaces after her name indicating this test should be completely filled in. She then is entitled to a green cap, denoting an intermediate swimmer. This system is applied to all swimmers whether they are preliminary students or students of the school. I found that it offered a real inducement to them, and encouraged many of the seniors and intermediates to the point where they have passed not only the requirements of the second test but are working on the third, the test for advanced swimmers. Students who have passed the third test wear white caps and are recognized as swimming assistants. I accept their assistance in timing a swimmer, assisting in the instruction of beginners in shallow water and in surface diving, but never make them responsible for anyone's

safety. My swimming assistants now total about twenty, from two to four assisting with each class. Without doubt these assistants materially help the beginner to perfect her stroke, to learn proper breathing, to accustom herself to being under water and to overcome fear.

The glee club is an outgrowth of the inter-curricular classes in music. Meetings are held one evening a week and two and three-part songs are studied. Members of this club take part in our programs for teas and receptions and at graduation. The present membership is thirty-eight with an average attendance of twenty-five to thirty. The members made their own rules and an outstanding one is that any member who is absent two weeks in succession for any reason other than duty is automatically dropped from the club. This stimulates a desire for regular attendance.

How Bridge Is Taught

The bridge club is an outgrowth of class instruction in bridge. At the last meeting, thirty-three members were present and four notes of regret came from students who were on duty and could not attend. Their rules are similar to those of the glee club. This group, however, meets only twice a month. At present we have two groups: advanced players and those still uncertain as to some plays and who want the experience of playing progressive bridge. This eliminates the hopelessness that a comparatively new bridge player feels when she is compelled to match her wits against the more seasoned player. More important still, it gives the advanced players more pleasure and saves the beginner from many embarrassing moments. Contract bridge is also taught.

Each year the senior class presents two plays, the proceeds of which go toward the payment of the yearbook expenses. Attendance is regular and rehearsals progress smoothly. This year our annual presentation included two short plays, with a minstrel show during the intermission. A dramatic club has been formed by the September section of the 1933 class. The members of this club will present a short sketch in May and one in June.

Every year in January and February the members of the ukulele club meet and get the simplified chords for all the newest songs. Tuesday evenings from 8 to 9 are given to seniors and intermediates and Thursday evenings to juniors.

One evening every other week (alternating with the bridge club) volley ball is played. Students don gym suits and take an active part in this game. Teams have their own leaders.

Among the most important activities in the winter program is the social evening, a period devoted to informal dances, to which the nurses may invite

men friends. The interns have a standing invitation. Social evenings start the first week in December and end the last week in March. It is the only student activity that is carried over until 11 p.m. Nurses and their friends seem to enjoy this entertainment which is held in the residence hall. From seventy-five to 150 persons attend. The social director provides the music.

The latest novels and a variety of magazines are provided by the library committee and members of our board of directors. Students act as assistants in the management of the fiction library. They pass on the list of books submitted every three months by the social director. The books may be obtained free of charge but a heavy fine is imposed on anyone who keeps new books more than one week. An inventory is taken regularly and the names of delinquent readers are published. Some of the more popular books have been reviewed by students in the current events classes.

Each month a dinner is planned for all nurses whose birthdays occur during that month. A great deal of attention is given these parties by the dietary department and a special dinner is served.

The graduate nurses' club has a large membership and interested officers. The meetings are always social affairs and no hospital business is transacted or even mentioned. The club meets one night a week. An informal dance is held one night a month for members and their friends. Bridge parties and swimming alternate on the other evenings, with an occasional skating party or a theater party. This club functions between October and May.

The school holds three formal dances a year, when the superintendent of nurses and the social director receive the guests. All other dances are informal. Teas, informal parties, the method of receiving preliminary students into the school and their required trips are all part of the program provided.

What This Program Teaches

It may appear that the program described is ambitious and extensive. It should be remembered, however, that it is our purpose to make the program so varied that it will include something of interest to every student. A chart posted on the bulletin board in the residence hall listing the students who are outstanding in school activities is an added incentive to participation in the classes offered. In taking part in these activities the students work and play together and so develop poise, good sportsmanship and group action. In other words, through organized recreation these young people learn and practice those rules that promote happy human relationship.

Figures Show Costs and Occupancy Not Lowered

By JOHN A. McNAMARA

Executive Editor, THE MODERN HOSPITAL

IN ORDER to determine the present status of costs of operation and the charges to the patient as well as the percentage of occupancy during 1930 and its possible decline, a questionnaire was sent out by THE MODERN HOSPITAL to 3,250 general hospitals in the United States.

These hospitals were chosen because they had a bed capacity of more than twenty-five beds and because they were not government controlled institutions. No mental hospitals, convalescent, children's, tuberculosis or other special hospitals were included for the reason that it was hoped the results would shed some light upon the economic conditions of hospitals that depend almost solely upon the support of the public for their existence. This support may be in the form of endowments, taxes, voluntary contributions or paying patients. Information other than costs and occupancy was requested mainly to gain some idea of the type of management of the hospitals and also to aid in giving as clear a picture as possible of the financial problems hospitals are facing.

Local Conditions a Dominating Factor

From the 3,250 questionnaires sent out, answers were received from 730 or 23 per cent. Not all of these, however, were complete in every detail, because in some cases this was not possible and in others the data were not available. Hence, throughout this report there will be a variance as to figures used as a base, but it is believed that the averages will be fairly accurate. Attention has been called to the probable degree of error when costs are mentioned. This difference results from the mode of figuring costs. Some hospitals include a certain amount for depreciation others make allowances for interest on investments while many do not take into calculation either of these factors. No division has been made on either depreciation or interest and the figures quoted will be those based upon the bulk of the answers irrespective of the method used in determining them.

It is perhaps well to sound a note of caution here regarding the application of any figures found in this report. It must be remembered that local con-

ditions are always a dominating factor and because one hospital reports low costs does not mean that it is more efficient than the hospital reporting high costs. Unless we consider living costs, labor costs, type of work performed and the demands of the medical profession, we cannot very well arrive at any conclusion that will justify a hard and fast rule as to just what is a fair cost or a fair charge.

Costs Maintain Steady Average

To illustrate this point ten hospitals reported a daily per patient cost of more than nine dollars. However in every case the hospitals proved to be efficiently conducted but outside influences were to blame for the high cost. Some of them were in California where hospitals are taxed and hospitalization is on a more elaborate scale; several of them were teaching institutions and the excessive cost should be attributed to medical education rather than to hospitalization.

On the other hand, several municipal hospitals of very large bed capacity reported a very low cost, sometimes lower than two dollars a day. Many beds, all in large wards, plus the fact that the hospitals are wholly free, tended to bring down the cost to these atypical figures.

The question regarding average costs per day per patient was answered by 547 hospitals, none of them institutions conducted by Catholic religious orders. The average for these hospitals was \$5.42. Forty-five Catholic hospitals showed an average cost of only \$4.20 and the average for all hospitals was \$5.33. These figures are somewhat surprising. In 1928 the American Hospital Association arrived at an average cost of \$5.32 for approximately 1,100 hospitals, and in 1929 the cost was \$5.30. Since that time food costs and labor costs have decreased materially although these factors may be counterbalanced by the lowered occupancy reported and possibly by the increased service demanded by patients. It will be interesting to compare the figures next year with the 1930 figures because of the reduction of salaries in some hospitals together with a decrease in operating expenditures of about 5 per cent in most institutions.

The reason for the division of Catholic and non-Catholic institutions is obvious. The Sisters have dedicated their lives to hospital work and receive no salaries. Inasmuch as this relieves the hospital of one of its largest items of expense—salaries for executives—the costs in these institutions are bound to be lower. However, as against this comes the expense that every Catholic Hospital faces of taking care of both the novitiates and the aged in its Order but this does not balance the advantage of no salaries.

In some cases hospital administrators were able to estimate their cost for private rooms and wards but as a general rule this was not done. It is admitted that there is great danger of error in attempting to figure these two classes of accommodations separately. Some administrators claim that it costs more to provide ward service than private room service because of the special nurses used by private room patients. This relieves the nursing load and the nursing costs, whereas ward patients seldom have special nursing. However 116 hospitals did report on these charges and the average determined was \$5.92 for private room service and \$4.17 for ward service. Probably if this were extended to all of the 730 hospitals reporting with the average of \$5.33 per day for all types of rooms, the figures would be nearer \$6.33 for private room costs and \$4.33 for ward care, a spread of \$2 which might be equalized by the factor of special nursing.

Charges for room, board and nursing for patients are practically impossible to figure. Certainly the average does not go above \$7 a day although some hospitals show charges as high as \$20 a day while others show as low as \$2.50 a day for private rooms and \$1.50 for ward beds. No accurate averages were worked out because it was thought that any figure would be misleading.

Little Change in Occupancy Percentage

The next consideration is the percentage of occupancy during the past five years. Not all of the hospitals answering have been in existence for five years so the average has been based upon only those that could supply the figures. The study shows that the average occupancy for five years in 266 hospitals was 67 per cent. The decrease from the 1929 occupancy to the 1930 occupancy is surprisingly small. In 1926 the average was 65 per cent; in 1927 it was 67 per cent; in 1928 it was 68 per cent; in 1929 it was 69 per cent, and in 1930 the drop was only 1 per cent—to 68. The explanation of this comes, however, when we consider the increased occupancy reported from municipal hospitals and the decrease among the pay patients in private hospitals. County hospitals show an in-

crease in occupancy from as low as 51 per cent in 1926 to as high as 92 per cent. A state hospital for acutely ill shows an increase of from 50 per cent in 1926 to 93 per cent in 1930 and one city hospital shows an increase of from 72 per cent in 1926 to 102 per cent in 1930. If these were excluded a much greater decrease would be noted among the private hospitals, particularly among the privately owned small hospitals in the larger cities.

Sources of Income

Five hundred and fifty-two hospitals reported on free, part-pay and pay work, and the averages show that 23 per cent of all the work in these hospitals is classified as free, 22 per cent as part-pay and the remaining 55 per cent as full-pay. This would mean that at least costs must be obtained for the part-pay cases and that 23 per cent profit must be made on pay cases if the books are to balance. This does not consider, on the one hand, the loss by bad debts and, on the other, profits from special services. However few hospitals realize a profit of 23 per cent on the average private room and hardly any realize the full cost of hospitalization for part-pay cases.

Difficulty was encountered in the attempt to learn of earnings from the various departments of the hospital, such as laboratories, physical therapy, x-ray, pharmacy and so forth. The largest number of replies pertain to laboratory profits, in which 63 per cent said they made a profit, 31 per cent said they made no profit and 6 per cent maintained they had a loss. Of those who answered the question regarding the x-ray department 81 per cent admitted they made a profit, 17 per cent claimed they made no profit and 2 per cent stated they had a loss. The pharmacy shows a profit in 52 per cent of the hospitals reporting, no profit in 44 per cent and a loss in 4 per cent. The costs of the other departments are not kept separately in all hospitals and therefore any report would be erroneous.

Income from others than patients and from endowment was reported by many hospitals. Some of this aid comes through the government, the state, the city or the county, while a few reported subsidies from universities.

Only 124 are members of community chests and only twenty-six reported any aid whatever from churches. This last is surprising because of the large number of church hospitals other than Catholic churches that sent in answers to the questionnaire.

Two hundred and forty-five hospitals replied that they had endowment funds, 75 per cent of this number being in the fourteen states east of the Mississippi River and north of the Ohio River. Sixty per cent were in cities of less than 100,000,

which is surprising, while 40 per cent were in the larger centers.

The idea of endowments does not seem to be popular or perhaps to be understood in the southeast, the southwest or the northwestern portions of the United States. One wonders if this is because in these localities population is sparse and scattered and there are a large number of "doctor owned" hospitals serving the communities, which are not in a position to ask for endowments.

Five hundred and ninety-eight or 84 per cent reported that they maintained out-patient departments. This is an encouraging sign because until a few years ago the out-patient department was looked upon with some disfavor among the medical profession. Indeed a city of more than 30,000 inhabitants in Michigan is still without an out-patient department because the doctors will not sanction it.

Eight per cent of those reporting stated that they had a connection with some convalescent hospital while 92 per cent had none. A great deal has been written about the need for convalescent care and these figures give evidence that attention must be given to convalescent hospitals within the near future.

As surprising as some of the other answers is the one that 20 per cent of those answering stated there were not enough beds for the community while the remaining 80 per cent felt "there were enough. These of course are only opinions and do not settle the matter one way or the other. In times when occupancy is low the superintendent is apt to feel that there are more than enough accommodations, whereas if the same question had been asked early in 1929 undoubtedly more superintendents would have been prone to say that there was a shortage.

Facilities Not Used Enough by Staff

Most hospitals reported that the facilities of the institutions were used by doctors in the examination of patients but few stated that extensive use was being made in this way. One superintendent writes: "Outside patients may be brought to the hospital by medical staff members for examination in rooms provided for that purpose. X-ray, electrocardiograph, basal metabolism and general laboratory services are available for these patients. It is not necessary that they be admitted as bed patients. Charges have been established for these services. These services are used to a great extent by both the attending and the courtesy staffs."

Another superintendent says: "In May, 1930, the board of governors equipped a department as a health inventarium. Patients are sent for x-ray and laboratory work, for electrocardiograph and

metabolism tests. These departments are used continually by attending physicians as aids in diagnosis in their private practice."

Here is another opinion: "The members of our staff do not use the examining rooms of the hospital for private patients unless such examinations require apparatus or instruments that the doctor does not have in his office. The question has been brought before the staff of using the hospital for their private work. I believe this should be encouraged but not until a new dispensary unit is built."

It is believed that the trend is definitely toward the doctor having his office at the hospital but it may be some time before such an arrangement is common practice.

Four questions concerned the division of the hospital into wards and private room accommodations, the object being to learn whether such divisions were made logically, based upon community needs, or upon impulse, and upon whom rested the decision. The answers were disappointing in that the few who did answer could not give the information except in rare cases where surveys had recently been made. Some hospitals were too old to find out, while the majority have made little or no effort to divide the hospital in any way that will prove economical in its operation. To have 100 private rooms and fifty ward beds when the community demands are the reverse must prove to be a costly mistake.¹

A Short Story of Progress as Told in Figures

Statistics do not always make the most interesting reading in the world but there are times when, judiciously used, they present as a similar amount of reading matter could never do a picture of the rise or fall—or both—of an institution.

In the case of the Mt. Sinai Hospital, New York City, one small statistical table in the hospital's annual report for 1930 is sufficient to portray graphically the progress and the success of that institution over a period of seventy-three years.

The table is here presented.

Year	Patients Treated in Hospitals	Hospital Major Surgical Operations	Con- sul- tations in O. P. D.	Disbursements for Maintenance of Hospital and O. P. D.
1857	216	46	None	\$ 9,000.00
1860	297	46	None	14,000.00
1870	663	225	None	20,000.00
1880	1,437	240	9,922	44,476.10
1890	2,862	1,049	43,560	100,000.00
1900	3,145	1,472	86,431	135,272.00
1910	7,613	3,840	115,726	410,000.00
1920	9,548	5,015	173,682	899,704.97
1930	12,179	7,707	222,489	1,785,244.23

¹Read at the Hospital Standardization Conference of the American College of Surgeons, New York City, October 12-15, 1931.

The Hospital's Important Rôle as a Public Health Agency

By ROBERT E. NEFF

Administrator, University of Iowa Hospitals, Iowa City

COMMUNITY health—it's everybody's job. Cooperation between the various groups, both private and state, lay and professional, that are working for social betterment is the basis on which a sound public health program must be developed.

Lay organizations owe their position to a realization by the public, expressed through representative groups, that each community needs constant and intelligent supervision and education along public health lines. Some of these organizations were brought into existence for purposes quite foreign to public health, yet their activities have been gradually expanded to embrace consistent support, either financial or moral or both, of some particular phase of health protection. Other groups were organized for the specific purpose of developing a health campaign along some particular line, as for instance, the antituberculosis associations. The activities of these organizations have developed a local psychology exceptionally favorable to the promotion of public health work.

How Volunteer Agencies Have Helped

Mention should be made of the tremendous importance of the many volunteer agencies. The Rockefeller, Milbank, Rosenwald and other foundations, as well as a number of insurance companies, deserve much credit for the work they have done for the benefit of mankind. Tuberculosis associations, public health nursing associations, societies for crippled children, mental hygiene groups, heart associations, cancer research organizations and scores of lay and professional agencies as well as many social agencies are making a contribution of inestimable value to the program of preventive medicine and public health. They have demonstrated that educational methods are effective in the prevention of disease and in the reduction of death rates and that such weapons are legitimate for use in our public health programs.

The jurisdiction of the state must be recognized in all matters pertaining to public health, but the state without the aid of an orderly and intelligent application of all defenses available in the field of

public health will be found woefully lacking in its ability to meet the needs for a practical and definite program of health preservation. Protecting the public health is the particular concern of governmental or official health agencies. While the amount and type of health protection in the community rest to a large extent with the citizens of that community, they rest to a greater extent with the officials who are charged with those duties. Official agencies must be relied upon to exert their authority for the protection of health or to establish and conduct medical and educational services for all classes in the community.

Many Groups Are Involved

The tremendous strides recently made in public health endeavors are the result chiefly of a more completely developed program and coordinated action on the part of all the participating groups. We live to-day in a world where even a single act has far-reaching reverberations among hundreds of other men. What we do independently and without the aid of others is of little avail. We are a part of a vast scheme of cooperative activity and we have to be a cog in the machine whether we like it or not.

The constituent agencies of a public health program are numerous but it must be granted that medical care, as represented by the services of the physician and the hospital, is the predominating service in such a program. Hospital care and medical care are definite responsibilities of the community. A community is no healthier than the individuals who comprise its citizenry.

The modern hospital has evolved from the simple "boarding house for the sick" into a vast hospital system. In addition to caring for the sick, the hospital has had to assume other responsibilities. Because of the facilities it affords, it has become the educational center for the training of physicians, nurses, social workers, dietitians, technicians and those in allied professions. It has become the center of medical research and a vital factor in the field of public health and preventive medicine.

The rapid growth of the hospital need not be discussed here in any detail. It must be appreciated, however, that the hospital has grown so rapidly in response to the public demand that it now represents a billion dollar business and takes its place with the most important enterprises in public life. A business so extensive calls for specialized and scientific management. There is perhaps no enterprise to-day where organization and effective management are so vital as in the modern hospital. Human life is at stake. Where is there in our society an enterprise the conduct of which involves such responsibility as is the case in the hospital, with its responsibility for the life and health of the ten or twelve million persons it cares for each year? Efficiency is the keynote in hospital organization, efficiency in its every phase, in economical maintenance as well as in the care of the sick.

Keeping Up With the Times

Just as healing has become a science, so has hospital management. The hospital has been carried along in the development of medical science. As the workshop of the physician and the fountainhead of medical research it has had to assume vast responsibilities. The Utopia has not yet been reached, nor can we complacently sit by and feel that the hospital has reached a status that cannot be excelled. The older we become in hospital service, the more we are convinced that every day brings a new lesson, a new and better way to conduct certain phases of the work. We must be alert, progressive, forward looking in order that our institutions may keep abreast of the rapid developments of medicine and public health.

The hospital's educational and research functions are being widely extended in the field of medical practice and public health, with a consequent wider service to the community. The hospital is not only a workshop for the physician and a place where the sick and injured may be treated, but an institution where the study of disease may be conducted to the best advantage. It is most compelling when it is considered as the logical center about which research and investigative endeavors revolve. The hospital more than any other social agency accumulates evidence regarding the dangers of life in a community—the dangers from contagion, from ways of living and from industry, and it must assume the responsibility to study this evidence and become the leader in the program of preventive medicine and public health.

The strategic part played by the hospital in preventive medicine is demonstrated by the fact that the major achievements in modern medical sciences have emanated from the hospital. The hos-

pital must be conscious of the fact that the accent in the practice of medicine has changed from curative to preventive. The research projects conducted through it have resulted in the perfection of many procedures that contribute positively to public health and the prolongation of life. The Schick test, the Dick test, sodium amytal, nembutal and other new types of anesthetics, the insulin treatment as well as scores of other discoveries have come from the research and investigative departments of the modern hospital. Through these researches, the hospital and the medical profession are emphasizing the importance of preventive medicine. Unless the prevention of disease becomes the dominant practical idea of physicians and health workers, we shall lose the best opportunity ever afforded medicine and public health to work for the betterment of mankind.

The modern hospital, therefore, with adequate facilities for the care of the sick and injured, is potentially an investigative laboratory for medical science. Too little, perhaps, does the average individual appreciate the importance of the hospital in the field of research and investigative medicine. There was a time when institutions engaged in scientific investigations were enshrouded in a veil of mystery and were regarded with suspicion by the public. It is gratifying to note the change in this attitude during the past decade. A growing appreciation of the teaching and investigative functions of the hospital is developing and no longer does the general opinion prevail that experimental medicine reacts unfavorably upon the care of the patient. In fact, it is becoming generally recognized that where the student and intern are best taught, there the patient is best treated. The hospital without the teaching function or the will to promote investigative work will be considered less progressive and less safe perhaps for the best care of the patient. Its excellence in respect to diagnosis and treatment of disease depends to a great extent upon how it fulfills the teaching and investigative function.

The Source of Medical Research

The acid test of the importance of anything in life is to consider what life would be without it. Applying this test to the hospital gives us a clear idea of its importance in the field of investigative medicine. Without the hospital as the source and fountainhead of medical research, we should find ourselves sadly handicapped.

All hospitals do not have facilities for conducting extended investigative programs, but practically all can contribute to the advancement of medical science by recording and publishing in-

formation regarding processes that have been accomplished within its organization. We must not discount the importance of the smaller hospitals in this direction. The cure for cancer or for other now incurable diseases may be discovered through a clue emanating from one of our smaller hospitals, comparatively insignificant in the field of investigation and research.

An organized and well defined program of medical research is costly. Physical plant, equipment, publications and above all a group of workers with zeal and determination are requisites that call for a large expenditure of funds.

How Hospital Facilities Have Improved

The demands of preventive medicine and public health have contributed abundantly to the development and growth of hospitals. The rapid advancement in the medical sciences, with the improved methods in the treatment and care of the sick and injured during the past two or three decades, is an outstanding phenomenon. During the last half century the population of the United States has somewhat less than doubled, while the number of hospitals has increased fiftyfold.

The unique and privileged position of the hospital in its dealings with the patient has been radically and in all probability permanently invaded. In the past the hospital alone was responsible for the care of the physically handicapped and for the public health. To-day those who aid the hospital in health matters are increasingly tending toward co-workerships rather than subordinate assistantships. The hospital no longer has complete responsibility or full authority but shares with the various cooperating health agencies responsibility concerning the patient and his relationship to the public welfare. It is therefore carrying not an absolute but a divided responsibility for the complete care of the patient. Even though it considers itself a vital part of the health program and assumes its responsibility accordingly, that responsibility which at one time focused almost entirely on the hospital is now diffused over the entire field of public welfare. The various health agencies are gaining in their progress in professional autonomy, with an increasing measure of independent responsibility, and are carrying on a crusade for recognition which means for them a deserving position in the public esteem.

The majority of our social inadequacies to-day are due to or are closely related to illness and disease; consequently, it is incumbent upon the hospital to ally itself closely with the various social agencies of the community. The hospital should not relinquish its responsibility when a patient goes home. Time was when the hospital was merely

a hotel for the sick, and when it took no more interest in the departing patient than the hotel keeper took in the departing guest. Happily that era is past. The patient is now an object of interest and real concern and every effort is made to restore him to a normal social environment. Obtaining the end results in hospital treatment of a patient is important, but keeping the patient well is a matter of as much concern as getting him well. The hospital should not be satisfied with getting these end results but should retain its interest in the former patient, just as a school retains interest in its students who have graduated and gone out into the world. Restoration of a patient to a normal status, while definitely a responsibility of the hospital, cannot be accomplished without the aid of many cooperative agencies.

In order to obtain the maximum benefits from the many agencies in the health field, we must give particular care to coordinated and cooperative action. Only through a recognition of this can we have a unified constructive and permanent public health program. There must be a centralized agency about which must gather the various independent agencies as integral parts of a health program. The state department of health should be recognized as perhaps the logical agency around which these activities must function. The county health officer, who should serve full time in every county, will be coordinator. Failure to recognize the importance of these principles in public health endeavors will hinder the proper development of an adequate health program.

Let the hospital therefore come to a realization of the fact that it is one of the many constituent agencies engaged in the promotion of public health and let us endeavor to strengthen and keep sturdy our link in the chain that pulls toward the goal of a complete and comprehensive program of public health and preventive medicine.¹

How Social Service Departments Are Distributed

How many hospitals have social service departments?

Recent figures compiled by the Association of Hospital Social Workers reveal the following percentages: 8 per cent of all hospitals; 10 per cent of all general hospitals; 54 per cent of all children's hospitals; 6 per cent of all tuberculosis sanatoriums; 24 per cent of all orthopedic hospitals; 14 per cent of eye and ear hospitals.

¹Read at the meeting of the Minnesota Hospital Association, Duluth, June 22, 1931.

Designing and Building an Oxygen Therapy Unit

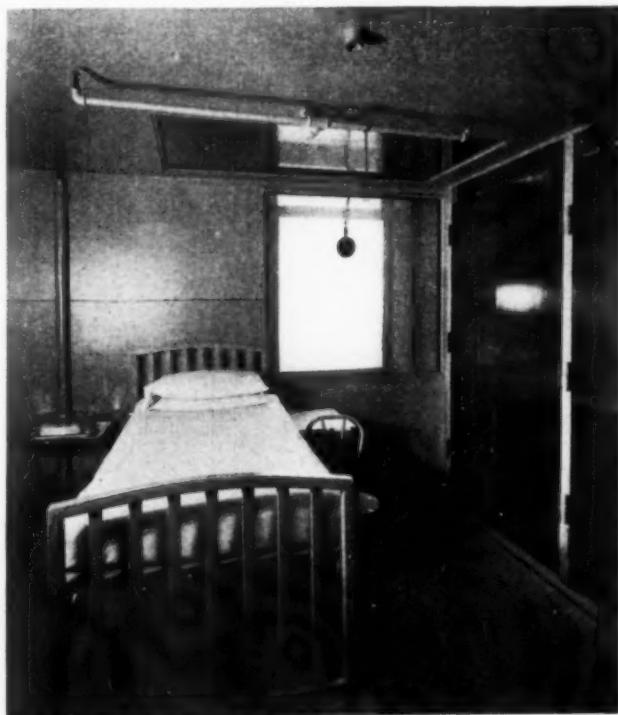
By CARL A. ERIKSON

Schmidt, Garden & Erikson, Architects, Chicago

AN INTENSIVE study of many of the oxygen rooms in this country was made prior to the construction of similar rooms at Michael Reese Hospital, Chicago, and an effort made to overcome the known or imagined objections to them. The basic principles of their design and construction are those developed by Dr. Alvan

patients' rooms and the anteroom. This anteroom is the nurses' workroom with a sink at one end and a worktable, a small case for supplies and a storage space for the oxygen tanks. In new construction, consideration should be given to providing bedpan disposal facilities in or adjoining this area. Attending personnel may observe the patients through the glass in the large doors to the rooms. These large doors are used only to admit and discharge the patients. Entrance to the patients is through the air lock or vestibule, a device not used by Barach but used by others. The outer door is always closed before the inner door is opened. This air lock reduces to a minimum the inevitable change in oxygen content and air condition—humidity and temperature—which is unavoidable when it is necessary for anyone to enter an air conditioned room.

Each room is 10 feet wide and 11 feet long with an 8-foot ceiling. The size was determined

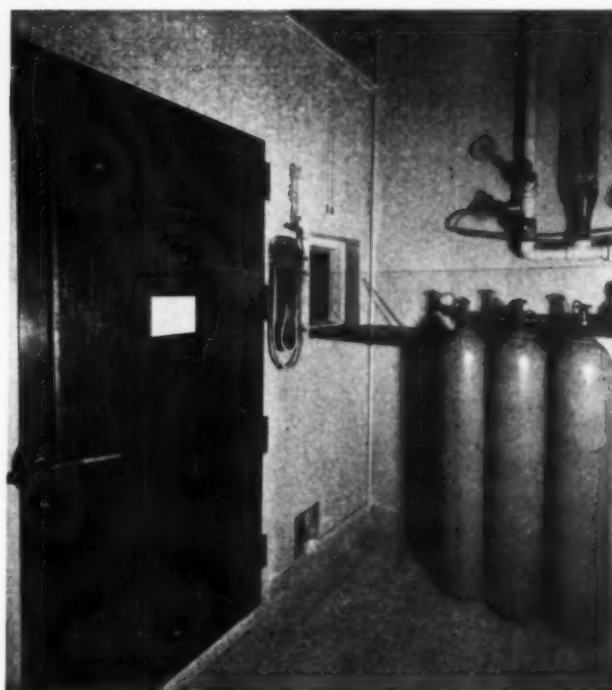


A view of the oxygen therapy chamber at Michael Reese Hospital, Chicago.

L. Barach at the Columbia-Presbyterian Medical Center, New York City.

The area assigned to these rooms at Michael Reese Hospital adjoins the medical wards on the third floor of the main hospital building. It may be entered from the main corridor. The distance from the corridor wall to the outside wall was approximately 19 feet. The long dimension, 24½ feet, was determined solely by the needs of the oxygen therapy rooms. The ceiling height was 14 feet, far more than was needed.

The plan indicates the arrangement of the two



Here we see the patient's entrance to the chamber, the wet and dry bulb thermometer and the tray door.

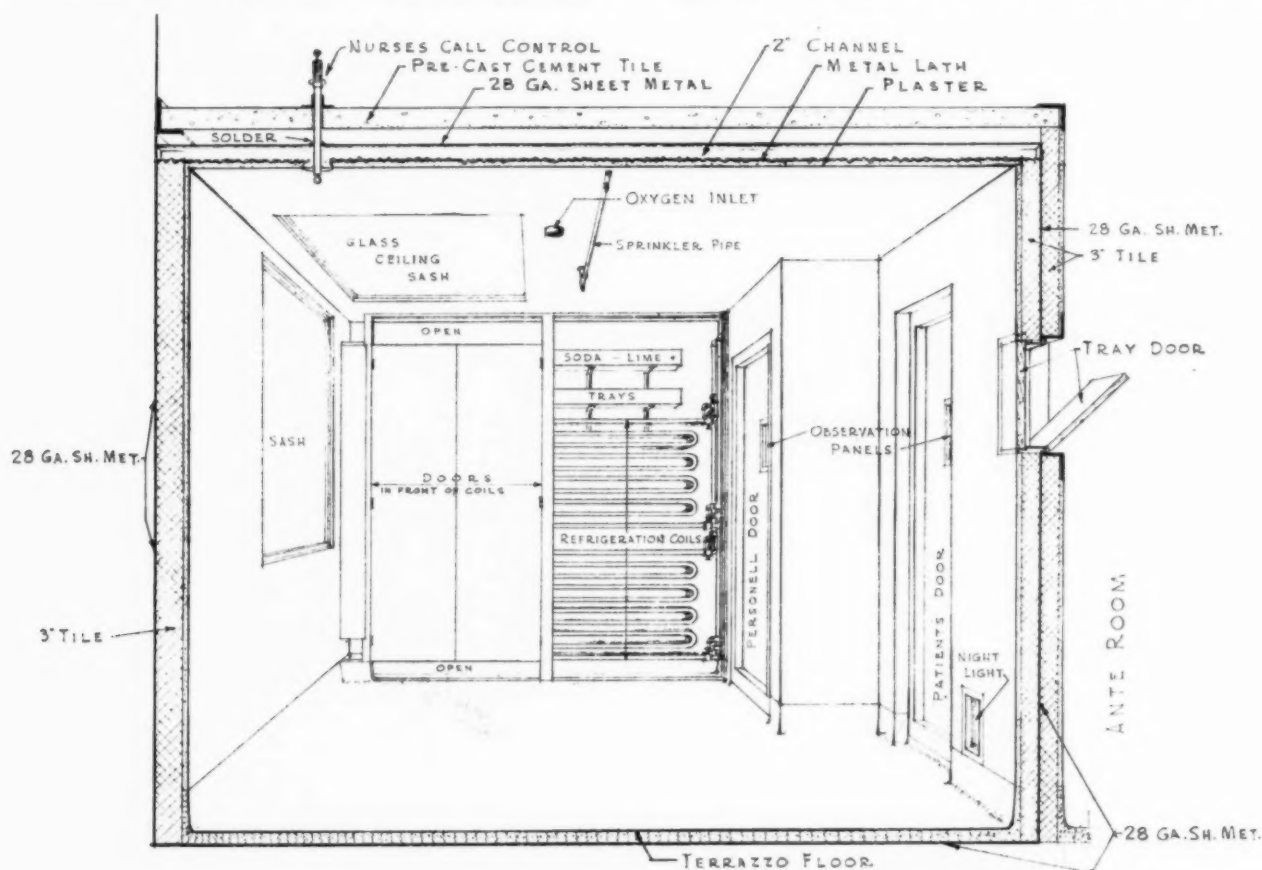
after the economies in oxygen consumption and in air conditioning in a smaller room were weighed against the areas required for the care of the patient and his mental comfort. The area has been found to be satisfactory. The equipment consists of a bed and a bedside table, a lavatory with a small case for supplies over it, and a radiator. The hinged sash at the window would have been fixed in position had it been possible otherwise to obtain access to the outer windows for cleaning.

The patients' rooms, of course, are the only areas that are air conditioned. Each one is independently controlled as to oxygen content, humidity and temperature. The oxygen is supplied from the six commercial oxygen tanks in the anteroom. All of them are interconnected through a manifold which leads to a specially designed muffler and a commercial valve and then through a 2-inch pipe into each room. This equipment will deliver 500 to 650 cubic feet of oxygen to each room in five minutes, the amount necessary to charge the room for the incoming patient. The oxygen content is thereby raised to 50 per cent. This concentration can be maintained over long periods of time by a steady flow of 12 liters of oxygen a minute. The oxygen content of the room is generally maintained at 50 per cent, but it has been maintained at 65 per cent with equal facility.

To control further the chemical content of the air, it is necessary to remove the carbon dioxide exhaled by those in the room. This is done by the soda lime in the trays over the refrigerating coils through which the air passes to the coils.

In rooms that are almost hermetically sealed, however, it is not sufficient merely to assure control of the oxygen content and its purity. The physical characteristics, the temperature, the humidity and the movement must also be controlled. Otherwise the room would quickly become unbearable. To obtain the utmost value for treatment purposes, the temperature should without doubt be controllable within a rather wide range. At Michael Reese these rooms occasionally have been kept at an almost constant temperature of 64° to 66° F. (although 70° is the ordinary temperature), even during the past summer when the outside temperature for days averaged more than 90° and frequently went over 100°.

The cooling mediums are the six brine coils that are concealed normally behind the doors at one end of the room. In Barach's rooms, the cooling coils are controlled by a humidostat; in these the coils are controlled by hand valves, a method that has been found to be quite satisfactory. The prevailing air conditions and the temperature and humidity desired in the room determine how many



Isometric view of the oxygen therapy room at Michael Reese Hospital.

of these coils are to be operated. When the room is first put into use the coils can all be used to bring the room to the desired temperature. The independent control of each set of coils, however, is primarily intended to permit the defrosting of the coils without interrupting the temperature and humidity control. While one set of these pipes is idle for defrosting purposes, another set is placed in use.

But temperatures of 64° to 70° may be too low for bathing the patient, for his physical examination and for similar procedures. An ordinary radiator controlled by a thermostat will bring the temperature up to 75° or 80° within ten or fifteen minutes. The steam supply is independent of the ordinary heating supply of the building so that heat is available in summer as well as in winter.

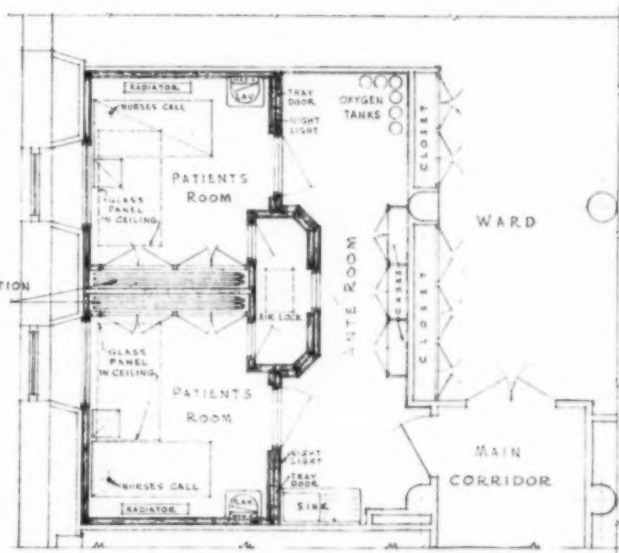
The refrigerating coils have a dual purpose. In cooling they also dehumidify the air to the desired relative humidity, 25 per cent, at which these rooms are usually kept. Such a process requires constant overrefrigeration. In the balancing of this overrefrigeration, the temperature control on the radiator plays an important part in automatically keeping the room at the predetermined temperature. By means of convection currents the air is kept moving without the aid of a fan. The doors in front of the cooling coils conceal them and yet permit easy access. The coil space is 1 foot deep, 8 feet 9 inches long and 8 feet high. When the cooling coils are working, this space makes a flue in reverse gear. The cold air descends to the floor, passes under the door and across the room and rises to the ceiling where it passes again into the flue through the opening between the top of the doors and the ceiling. From there it goes through the soda lime boxes where the CO_2 is removed and then over the brine coils from which point it begins the journey all over again. The results have been excellent.

Eliminating Explosion Hazards

Any room with a relative humidity of only 25 per cent and with varying percentages of oxygen up to 60 per cent is potentially dangerous. Electric sparks caused by switches, bursting lamps, crossed wiring and oil are sources of danger. Therefore all of these things are kept out of the room. Three sources of electric light are available, all of them outside of the room: (1) general illumination from a fixture directly above the glass panel in the ceiling; (2) a kind of bracket light in the window of the room; (3) a night light that shines through a small window directly opposite the foot of the bed. The nurses' call is of the "pull switch" type. The switch is above the ceil-

ing of the room with the cord operating through a gastight sleeve in the ceiling. Pilot lights of the ordinary type are over the door from the main corridor to this unit. As a further safety measure, each room has two sprinkler heads supplied by 2-inch pipe and controlled by pull chain valves.

Perhaps the greatest difference between these rooms and practically all other oxygen rooms is in



Floor plan of the oxygen therapy room.

their appearance. If the oxygen room seemed to the patient to be like the rooms to which he was accustomed and less like a steel lined brig, it was thought that the mental reaction would be favorable. If ordinary building materials could be used it was hoped that the building costs could be lowered. Neither of these benefits can be demonstrated to the satisfaction of a skeptical accountant—the first because the influence of the mental reaction in the curative process cannot be measured in pounds, minutes or dollars, and the second because there is required the construction of rooms of exactly the same size and equipment but of different interior finish, at exactly the same time and place. This last was not done, but the architects' preliminary studies indicated a considerable saving in construction costs over the metal lined room used ordinarily for this purpose.

An oxygen room is, to describe it roughly, a huge metal can. It must be of metal. Otherwise the oxygen will leak out even through plastered partitions. All joints in the metal must be gastight and the walls must be insulated to avoid excessive demands on the refrigeration that is necessary. There are several ways in which this may be done, most of them expensive. The rooms at Michael Reese are also metal containers, but ordinary clay tile, plastering and paint were applied on the inside, and on the outside, too, except where

existing partitions obviated the necessity for new construction.

Over the existing fireproof floor construction a pan of 28-gauge galvanized iron was laid. To this 28-gauge vertical pieces were soldered and these in turn were soldered to the ceiling, held in place against the 2½-inch precast cement roof. Large pieces of sheet metal were used in order to reduce soldering to a minimum. The sheet metal was soldered to the steel frames used at all openings. In this gastight metal can, the interior finish was applied and 3-inch tile walls were built inside of the sheet metal. Where the entire partition was new, an outer 3-inch tile wall was first built. This was necessary, first, to support the thin metal walls, second, to avoid the necessity of carefully finishing the outside of the sheet metal and, third, as added insulation. The floor and base of terrazzo were then poured directly on the bottom pan. The walls were plastered directly on the tile. The ceiling plastering was on wire lath fastened to 2-inch steel channels which were in turn carried on the tile partitions.

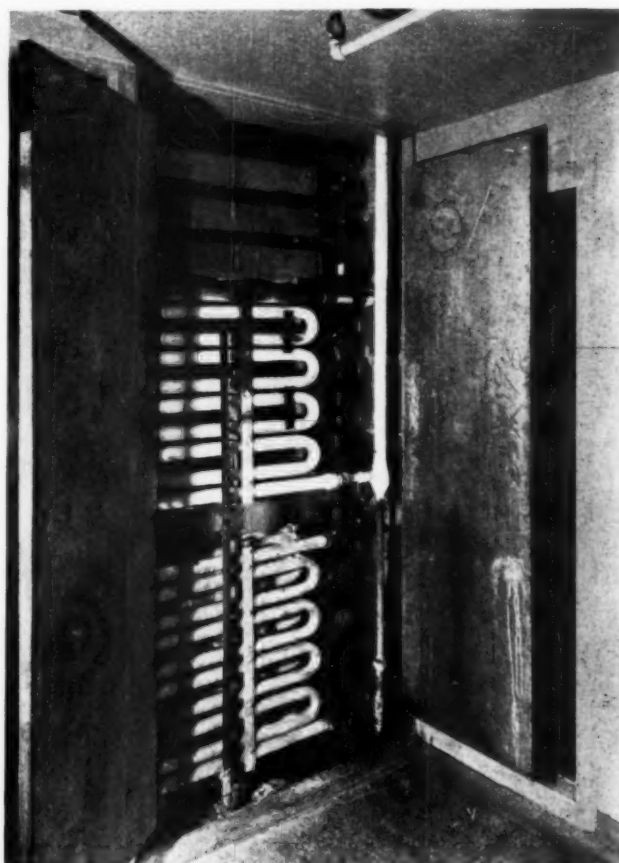
Special Precautions Against Leakage

The metal container is exposed only in the refrigerating coil space where it cannot be seen except when the otherwise concealing doors are opened. Since the surfaces here are likely to be wet because of the condensation, the space is lined with 20-gauge zinc soldered top and bottom to the other sheet metal. The bottom pan is connected to the sewer.

Openings into this room were carefully designed to prevent leakage. The windows are all of two thicknesses of glass, with an air space between. Each glass is set in rubber gaskets between stops that are removable to permit the washing of the windows. The tray door is doubled, each part closing against rubber gaskets. The large doors used for entrance and exit are 1¾ inches thick. All doors are fitted with rubber gaskets, and a special three-point locking device wedges the door tightly on all four sides against the jamb. Over the joints around the large door, which is used only for the entrance and discharge of patients, it is customary to apply a narrow strip of adhesive tape.

The cost of the unit was \$4,500. This was possible, however, only because of the efficient work of the hospital's own maintenance crew who did practically all of the erection and all of the mechanical work under the direction of the chief engineer and superintendent of buildings, William Craine. The costs do not include any allowance for the costs of the existing space in which this was built or any allowance for its pro rata share of the cost of the existing plumbing, heating and

electric refrigeration. If similar items were ignored, the cost might be slightly less in new construction. If contractors' profits were added to the union scale of wages the costs would be considerably more. The cooperation of Dr. Herman Smith, superintendent of the hospital, and of Dr. William



In the cooling chamber there are three independently controlled coils in each tier.

Thalheimer, director of laboratories, was invaluable. The rooms were made possible by the gift of a friend of the hospital.

The costs of operating these rooms are similar to those usually incident to caring for any seriously ill patient, except for the oxygen, the soda lime and the cooling. These rooms have been kept at the usual 50 per cent oxygen concentration with four cylinders of oxygen a day. A small amount of soda lime is used to remove the CO₂. The amount of refrigeration varies with the temperature.

While these rooms were designed primarily for oxygen therapy, it is interesting to speculate on other possibilities. It would obviously be simple to substitute many other gases for oxygen. As the rooms are practically dust and pollen free, their use for hay fever and asthma relief might be considered. With little added equipment, it would be possible to reproduce the humidity of a London fog.

Factors That Link the Hospital With State Health Work

By HUNTINGTON WILLIAMS, M.D., DR. P.H.

City Health Department, Baltimore

IN 1913 the governor of New York State appointed a special public health commission to study the health needs of the state. Its chairman was the late Dr. Hermann M. Biggs, recognized throughout the world as the most outstanding health administrator since the time of Sir Edwin Chadwick. Among the major results of that commission's work were the reorganization of the state department of health on a scientific and nonpolitical basis, the creation of the public health council and the establishment of the state sanitary code.

A year ago Governor Roosevelt appointed a similar state health commission for the purpose of ascertaining present day and future needs in order that modern health protection might be assured for every city, township and village throughout New York State. The present commission has for its chairman Dr. Livingston Farrand, the distinguished president of Cornell University. The group consists of fourteen recognized leaders in medical and social spheres, and has associated with it seventy-five other experts on committees studying particular health topics.

New York Inaugurates New Health Program

In February this commission presented to the Governor a preliminary report outlining what is now referred to as the new state health program. This report resulted in the introduction into the legislature of the so-called Wicks-Hutchinson health bill which embodied the major recommendations of the commission. First among these was the mandatory organization of county boards of health in all counties in the state, except those of New York City, and the appointment of a full-time county health commissioner in each county. This provision was considered by the commission as the most vital of all the needed changes in health administration in the state, and many of the other recommendations revolved about it. The leading authorities on the matter throughout the world are agreed that for adequate health administration the executive officer should be trained and qualified in his specialty and should devote his

entire time to it. In England the part-time health officer has long since disappeared, as has the part-time school superintendent of former years in this country.

The commission also recommended that in all cities of more than 50,000 population health officers hereafter appointed be required to serve on a full-time basis. The establishment of three additional state tuberculosis sanatoriums of not less than 200 beds each was urged, the primary purpose of these sanatoriums being to receive patients from counties that were too small to maintain such provisions for themselves. There are twenty-five such counties in the state, with a total population of about one million.

Facilities for Cancer Control Needed

In connection with city and county health departments it was recommended that more adequate provision be made for public health nursing service and for protecting the health of mothers and children. The establishment of a cancer control division in the state department of health was urged, this division to have as its nucleus the State Institute for the Study of Malignant Diseases, Buffalo.

It was also recommended that provision be made for the diagnosis and treatment of venereal diseases as a public health problem, that state and local services for the discovery and care of crippled children be extended, that the present authority of the public health council to establish qualifications for certain public health personnel be extended and that the public health law be amended in regard to sanitary control of public water supplies and pollution of streams by industrial wastes and further amended so that the inspection of industrial establishments in towns and villages no longer be the duty of the local health officers in these areas.

Naturally the relationship between this new state health program and the hospital field is of peculiar interest. In my estimation there is no public health activity that does not directly concern the hospital administrator. In a community where the water supply is not adequately pro-

tected at any moment there may be needed a typhoid ward in a general hospital, or perhaps a whole typhoid hospital service. Where toxin-antitoxin has not been given to at least 35 per cent of the children of preschool age a contagious ward or building with intubation facilities is a prime community necessity. From areas served by unpasteurized milk may come cases of septic sore throat and undulant fever as well as surgical tuberculosis, with their problems of diagnosis, treatment and prevention. What hospital is unconcerned with the ubiquitous public health nurse and her good work in securing clinic or out-patient service for the indigent? How can a decision be reached as to whether a general hospital should add wings for mental, tuberculous, maternity or contagious cases without a careful survey of the public health facilities existent and needed in the area to be served?

Prevention Is the Watchword

Just as in the practice of medicine so in hospital administration, we can see that the motto for the years ahead is "Diagnosis, Treatment and Prevention." I know of an instance in which the hospital history of a typhoid fever case led the institution to the inevitable conclusion that there was a typhoid carrier on the farm from which the patient came. The medical chief and intern discovered the carrier and called the state health department on the telephone to say that their surmise had been proved correct by the laboratory. The development of numerous typhoid cases was thus prevented.

Nationwide education has taught the public to seek a "keep well service" from the family physician. The public is saying to itself that much if not most of modern illness can be prevented or at least postponed. Those who through no fault of their own are unable to afford a family physician are knocking at the hospital doors and asking for "keep well" advice for their children and for themselves. What an opportunity lies before the hospitals!

The Hospital of To-Morrow

Those of us engaged in public health work envisage the hospital of to-morrow as a vital center for the health education of its clientele. Its medical staff will concern itself with the teaching of health and the prevention of disease as well as with diagnosis and treatment and its nursing staff will add to the study of sanitation the extramural application of public health by affiliation with the local health department or with some such body as a visiting nurse association. I have just learned that nurses at the Glens Falls Hospital, Glens Falls, N. Y., spend a day a month in the field working

with city health department nurses or with county public health nurses.

The out-patient department of the future will scarcely allow the entry on its record of a child who is not repeatedly urged to receive toxin-antitoxin and vaccination. It will have the syringe loaded for the use of the busy practitioner who brings a child requiring this treatment to the hospital, and in its waiting room will be displayed pictures, posters, graphic charts and automatic lantern slides all devised to teach health lessons and supplemented by interesting health leaflets.

The social service department not only will be developed as a guarantee against economic abuses but will also provide home study and follow-up of such conditions as tuberculosis and the venereal diseases and their familial contacts or else will associate itself closely for this purpose with the local health department.

Instead of prenatal supervision being offered only to prospective mothers who plan to enter the particular hospital for delivery, we shall see a prenatal clinic or out-patient service available on a district basis for anyone in the neighborhood. Suitable arrangements with attending physicians and clinic personnel should be possible, especially when community chest or similar public funds form a part of the hospital income.

How Hospitals Can Aid Health Programs

It has been possible for me to sketch only a few of the many points of contact between hospital work and the new state health program. Rather than to attempt a more complete analysis of these interrelationships, it has seemed more profitable to call attention to a few striking instances in which any community health program needs help from the local hospitals.

In the past health departments have limited their field of activity to certain major problems of sanitary engineering and communicable disease control. To-day in order to attack the chief causes of sickness and death health departments must concern themselves with the whole problem of adequate medical care for rich and poor alike. So, too, the hospitals have hitherto concerned themselves primarily with the diagnosis and treatment of the sick. Modern science shows that the job is only half done if such curative service is not extended along preventive lines. Our tasks in health departments and hospitals are closely linked together. They will prove impossible of achievement unless we work out a satisfactory joint program for the great humanitarian purpose of improved community health.¹

¹Read at the meeting of the Hospital Association of the State of New York, Syracuse.

Feeding the Sick at Christmas at Home and Abroad

A department devoted to the discussion of problems confronting both the dietitian and the administrator, conducted by Anna E. Boller, Central Free Dispensary at Rush Medical College, Chicago

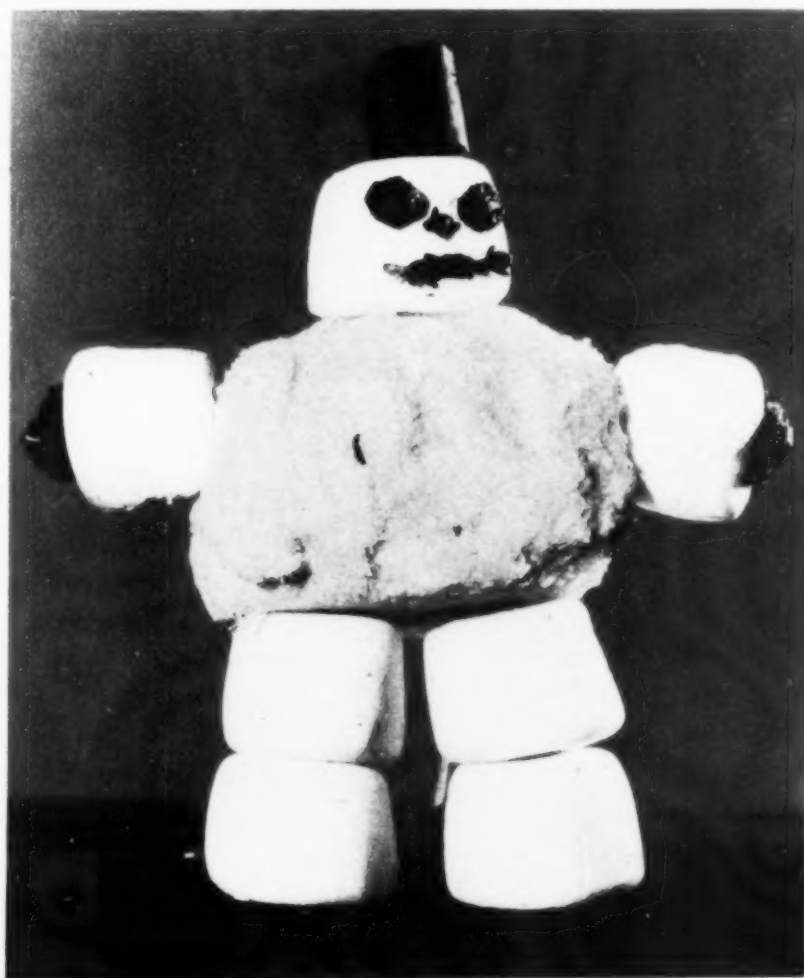
OUR Christmas custom, which dates back even to our pagan forebears, has such a strong hold on us that any interruption in the usual celebration makes us unhappy. Since festive family gatherings are synonymous with Christmas, when one member is absent the occasion is never quite the same. Especially is this true for the absent member who must spend Christmas in the hospital.

The staff and employees who have to be on duty on Christmas suffer from the same separation. It is, therefore, not surprising that the staff and employees in the hospital put forth every effort to make Christmas pleasant for the patients and in so doing create happiness for themselves. The interest on the part of the staff in assuming

extra work to help make Christmas pleasant for the patients is evident in many of the replies to a letter that was sent to a number of hospitals asking for information about the Christmas celebrations that took place in the various institutions.

Edith R. Tilton, University Hospital, Oklahoma City, Okla., writes: "The nicest thing about these preparations is that everybody is anxious to help. Tray girls, waitresses, persons outside the dietary department, come to us on their hours off duty and ask to help. This spirit is one of the happiest things in the Christmas season, and we all enjoy working on favors and cards as much as the patients enjoy seeing them."

The patient's appreciation of the work done is shown by the fact that several of the replies



Mr. Marsh M. Spongecake wishes you a Merry Christmas!

mention the length of time that favors are kept. Enid E. Miner, Wyoming General Hospital, Rock Springs, Wyo., tells of making crêpe paper roses for the trays which were so prized by the patients, a number of whom were miners, that many were still found in the rooms in June.

The general celebration begins on Christmas Eve or early Christmas morning with carol singing by the nurses in many of the hospitals. This usually is started in an assembly room and often is continued in the corridors and wards.

The first efforts of the dietary department are usually to be found on the breakfast trays. The problem of tray decoration is therefore a matter of great interest to dietitians and they are constantly on the lookout for suggestions. For this reason we have attempted to present a number of the original ideas carried out in various parts of the country and even in some of the larger hospitals in foreign countries.

Most of us associate cold weather, snow and crackling log fires with Christmas. Bernice McFarland, writing from the Seaside Hospital, Long Beach, Calif., draws a vivid picture of Christmas that differs from our cold and snowy holiday. She says: "There is no pelting of snowballs, no hustling of coal into the furnace, no jingle of



merry sleigh bells out here in Southern California at Christmas. Instead, the sunshine is mellow and flowers bloom in abundance—poinsettias everywhere, gardens filled with roses and orange groves brilliant with fruit and fragrant with blossoms. But the spirit is the same. Here, as elsewhere, Christmas trees, Santa Claus, decorations of holly and mistletoe and the singing of Christmas carols put into the air the joyous feeling of the Christmas season."

For the patients, the tray decorations are the

important part of the celebration. For breakfast and supper these usually consist of greeting cards, lighted candles or a sprig of holly or mistletoe, while the dinner trays have the most elaborate "fixings." A wreath of holly and mistletoe, on one side of which is a small holder with a red candle, was used for the morning tray in one hospital. A simple tray candle is made by pressing a red birthday candle into a green marshmallow or green gumdrop, fastening a "life-saver" on the side for a handle and placing the whole on a small round base of green paper as is shown in one illustration. A great variety of greeting cards can be made. The office force, the dietitians and the student dietitians will enjoy coloring these greetings in cheery reds and greens and decorating them with tiny gold stars and Christmas stickers. They are popular, attractive and inexpensive.

Maude Perry tells of the Christmas stockings that were personally presented last Christmas morning to each patient at the Everett General Hospital, Everett, Wash. These stockings were made of mosquito netting and were filled with the usual Christmas fruit, nuts and candy, and each one contained a joke gift, carefully wrapped.

On the Christmas tray this year at the Baptist Hospital, Houston, Tex., there will be a sprig of holly and mistletoe and a folder decorated with a silhouette cut out of black paper and a bit of holly put on with a brush in red and green. The greeting will probably read:

**Good Morning
The Baptist Hospital Staff
Wishes You a
Merry Christmas**

and on the inside will be the breakfast menu.

The dinner trays are more elaborate. The decorations range from paper napkins, tray cloths, snappers and nut cups to a number of original novelties which the dietitians make themselves.

Louise Yeomans Gilbert, Evanston Hospital, Evanston, Ill., tells us that they use candleholders, chimneys and stockings made of red crêpe paper and candies. The simple candleholder place card shown in one of the illustrations is one of her ideas.

Another dietitian suggests individual Christmas trees made by coloring spools and fastening a sprig of pine in them. They may be decorated with tinsel, one tiny candle and one small gift. In one of the children's hospitals these trees are made by sprigs of evergreen stuck into empty spools which are covered to make them look like

miniature pots. Another suggests the purchase of small artificial Christmas trees, which can be bought for two and a half cents each.

A miniature Santa Claus, illustrated here, is an attractive way of serving fruit, candy and nuts. He may be made as follows: A small red apple forms the foundation. Legs are constructed of seven raisins and a round cuff of a piece of marshmallow, 1 inch by $\frac{1}{4}$ inch, strung on a toothpick. A pecan, flat side down, forms the foot. Since the two legs will not support the weight of the apple, it is necessary to use two plain toothpicks at the back in order to make Santa stand firmly. Arms are made in the same manner, with the flat side of the pecan to the front. The head, a whole marshmallow, with a face drawn on it, or else a Santa sticker is used, is joined to the apple with a toothpick. Beard and hair are made of cotton and pasted to the head. A small piece of red paper in the shape of a cornucopia, pasted at the back, forms a cap for Santa.

Snow Men and Christmas Bells

Anna F. McCauley, Battle Creek Sanitarium, Battle Creek, Mich., offers a number of interesting suggestions with sketches and descriptions: "A snow man is made of white cotton with a black paper hat. He stands on the tray and looks quite wintry. A chimney nut cup is made of brick paper over cardboard. Sometimes a little snow hangs from it, so that it looks frosty, and little Santa Clauses clamber over the top. Christmas tree menus are made from red or green paper and are ornamented with gold and silver stars. The base turns back so that they will stand alone. Christmas bells are made of cardboard. They are large and are tied with silver cord. Flowers are made of gum drops and sugar coated almonds. Leaves may be obtained from the greenhouse to serve under these flowers."

E. H. Todd, Victoria General Hospital, Halifax, N. S., describes several of the interesting Christmas ideas used at her hospital. On the dinner tray everyone is given a red and green cornucopia, made from blotting paper and tied with ribbon. It is filled with fruit. A marshmallow snow man with a red paper cap, which covers the side dish used for nuts, raisins and candies, is added to the trays for private patients.

The decorations in the dining rooms for the doctors, nurses and help add greatly to their pleasure. Miss Todd goes to considerable trouble to create this Christmas spirit for them. She explains the use of red paper curtains at the windows and of the artificial window boxes filled with red paper poinsettias and pine. Each dining room has a tree and many of the decorations are

homemade—cardboard stars covered with artificial snow, pine cones gilded and cranberries strung on wires. Each table has a tall red candle on it and the lights have red and white fringed shades.

Miss Tilton reports beginning the day with red Christmas candles burning in pine cone holders on



each table. A large Christmas tree donated by one of the produce houses is decorated and lighted, and red wreaths with an electric candle in each are placed in the windows. Evelyn Anderson, Broadlawns, Des Moines, Iowa, gives an unusual touch by lighting the Brazil nuts on the candle salad. At her institution a roaring fire is kept burning in the dining room fireplace all day long, and the tables are decorated with poinsettias, "collected from patients who are glad to lend their flowers for use in the dining room at any time." Miss Perry arranges her tables in a hollow oblong, with three Christmas trees in the center connected with ropes of tinsel. Breakfast is eaten by the light of red candles stuck into blocks of wood painted green. The tables are decorated with tissue paper and

nut cups and the room is festooned in green and red crêpe paper. A Santa and reindeer stand in cotton snow on a small serving table near the door.

At the Seaside Hospital, Long Beach, Calif., quantities of poinsettias grown on the hospital grounds add Christmas atmosphere. The tables are decorated with 18-inch red Christmas candles stuck into an 8-inch square wooden base, covered with moss and cedar and holly twigs. Eugenia Shrader, Barnes Hospital, St. Louis, also has candles for each table. The candleholders are inexpensive and attractive. A teacup is turned upside down and a red candle about 8 or 10 inches tall is placed on the bottom. Melted paraffin is then poured around the base. Red crêpe paper skirts are then cut, rather full, and crimped at the top and the bottom and put on with a rubber band, under which is tucked a spray of holly.

A pretty custom used in some hospitals is that of serving fruit to the patients at the time of the mid-morning nourishment: Seaside Hospital arranges a plate of fruit, a tangerine on which are a few green leaves, two Lady apples and a cluster of raisins. Alta B. Hirsch, Miami Valley Hospital, Dayton, Ohio, reports that the hospital receives many gifts of fruit on Christmas which are made into small table baskets for the bedsides of ward patients.

The menu is usually the conventional turkey dinner. A few interesting additions to this dinner are listed, such as the candle salad with the lighted Brazil nuts, already mentioned. Winifred Cushing, Paterson General Hospital, Paterson, N. J., describes a grapefruit basket, filled with fruit and tied with red ribbon for the private room tray which makes an attractive first course. For supper she serves oyster stew, a fruit or an asparagus and pimiento salad and cocoa, fruit and cake.

Edible Candles and Candlesticks

Broadlawns last year was successful in trying to work into the menu things for which patients had asked. The dinner menu was:

Clear Soup	
Turkey	Dressing
Candied Sweet Potatoes	Creamed Onions
Candle Salad	Celery
Rolls	Cranberry Jelly
Fresh Strawberry Sundae	White Cake
Coffee	Mixed Nuts

Mary Elizabeth Smith, Baptist Hospital, Houston, Tex., says that Christmas breakfast there usually contains a new food, possibly cheese soufflé, in place of the customary ham and eggs. Most of their effort is concentrated on the dinner tray,

which she describes as containing the traditional roast turkey with giblet gravy, dressing (Southern style), cranberry jelly in paper cases, rice, green asparagus tips on toast with pimiento, Christmas salad (glazed red apples with cheese and nuts or blushing pears) or banana nut sticks piled log cabin fashion, candlestick salad and molded vanilla ice cream. She says that this dessert is satisfactory from every standpoint since it is something that can be enjoyed by the soft diet patients as well as the general patients. Although such molds are not new, she finds that there are many patients who have never seen them, and that those who have do not tire of them since there are new Christmas molds each year.

Ice cream molded in the shape of a candle and candlestick that may be lighted as it is served is an attractive addition to the menu. This may be ordered with pistachio ice cream for the candleholder, and raspberry or cranberry ice for the candle, with a tiny tape as a wick to be lighted when the ice cream is served.

A Feast in the South

Sara Hughes, Roper and Riverside Hospital, Charleston, S. C., says that it would not be Christmas dinner unless rice and gravy were served with the turkey. She gives the following typical Southern menu:

Breakfast

Half a Grapefruit Broiled Steak
Hominy or Other Cereal
Hot Biscuits and Butter
Coffee and Cream

Dinner

Oyster Cocktail
Celery Olives Salted Nuts
Roast Turkey Potato Stuffing
Cranberry Jelly Boiled Rice
Gravy Cauliflower French Peas
Creamed Potatoes
Orange Jelly Whipped Cream
Fruit Cake Coffee Mints

Supper

Deviled Egg and Sliced Tomatoes
Hominy or Other Cereal
Thin Bread and Butter
Baked Apple Stuffed with Nuts
Sweet Crackers Beverage

Miss Todd gives the following typical Christmas menu for the ward patients and notes that the help have the same with the addition of a bottle of ginger ale each. The same menu is served to doctors, nurses and private pavilion patients with

a few extras, such as grapefruit cocktail, oyster patties, curled celery and olives and ginger ale.

Breakfast

Oranges
Rolled Oats or Dry Cereal
Hot Rolls Jam
Boiled Eggs Tea Coffee

Dinner

Vegetable Soup with Crackers
Turkey Dressing with Gravy
Cranberry Jelly
Mashed Potatoes Spinach
Christmas Pudding Lemon and Hard Sauce
Nuts Raisins Candies
Fruit and Tea

Supper

Cream Tomato Soup
Cold Ham, Lettuce, Chow Chow, Sliced Peaches
Iced Fruit and Pound Cake Decorated with
Cherries and Angelica

Miami Valley Hospital serves Christmas dinner in two courses. A large tray is used for the cocktail, the dinner plate and the salad. A small tray on which are a Santa Claus mold, the coffee and a poinsettia flower is served after the removal of the main course.

Miss Tilton says that instead of individual servings of fruit at breakfast each one selects fruit from a centerpiece of bananas, apples, oranges and grapes upon each table. The unusual dishes on the dinner menu last Christmas were mashed sweet potatoes with pecans and marshmallows, creamed cauliflower with green and red peppers and mincemeat upside down cake with foamy sauce.

Western and Midwestern Menus

Seaside Hospital offers the following as typical of a California Christmas dinner:

Consommé Butter Flakes
Celery Stuffed Olives
Roast Turkey Oyster Dressing
Cranberry Sauce
Browned Sweet Potatoes
Artichoke Hollandaise Sauce
Salad—Grapefruit, Avocado, Walnut and
Persimmon, with French Dressing
Frozen Plum Pudding Lady Fingers
Candy Mints Salted Nuts
Coffee

Mrs. Shrader gives the correlated menu for the

three groups at Barnes Hospital, St. Louis:

PRIVATE ROOM	WARD	STAFF
<i>Breakfast</i>		
Grapefruit, Prunes or Oranges Oatmeal or an Un- cooked Cereal Ham Poached Eggs Biscuits, Toast	Bananas Cereal Soft Boiled Eggs Toast	Bananas Cornflakes Soft Boiled Eggs Cinnamon Rolls Jelly Coffee
<i>Dinner</i>		
Christmas Canapés Consommé Turkey with Oyster Dressing Mashed Potatoes B. Brussels Sprouts Avocado and To- mato Salad with French Dressing Cranberry Jelly Alaskan Combina- tion Christmas Cookies	Consommé Roast Chicken, Dressing Cranberry Sauce Mashed Potatoes Cauliflower Vanilla Ice Cream Tea, Milk	Consommé Roast Turkey, Stuffing Cranberry Sauce Mashed Potatoes Baked Onions Asparagus Salad, French Dressing Damson Plum Pudding with Lemon Sauce Fruit, Nuts Coffee
<i>Supper</i>		
Cold Tongue or Toasted Pimento Cheese Sandwich Parisian Potatoes Creamed Aspara- gus Stuffed Rose Apple Salad Damson Plum Pud- ding with Lemon Sauce	Vegetable Soup Creamed Aspara- gus on Toast Baked Potatoes Royal Ann Cher- ries Wafers, Tea, Milk	Oyster Stew Toasted Cheese Sandwiches Celery, Pickles Vanilla Ice Cream with Straw- berry Sauce Tea

In any consideration of the Christmas festival, the question of food costs must be studied. How much additional expenditure is necessary? Hospitals wonder if they can afford the extra expense. The statements of a few dietitians will throw light on this matter.

One dietitian reports that the cost per person for decoration usually comes to thirty-five or forty cents for the whole holiday season, which includes three trays on Christmas and one on Christmas Eve.

Another reports the average per capita cost for three years as a little over twenty-six cents a day and the average cost for the month of December for these three years was less than one cent higher. Apparently, therefore, the holiday did not cause any material increase in expenses.

In one instance where actual figures were impossible to compile the dietitian explains that the extra cost of the dinner represents only the difference between oysters and soup, turkey and chicken, with an added cost for salted nuts, candy boxes filled with mints and the fruit cake.

Another dietitian states that since chicken is always served on Sundays, the per capita cost for holidays is only a little more, being simply the difference between the cost of turkey and chicken.

A Western hospital reports that the turkeys are

grown in that section and that they pay less for turkeys than for chicken. Even with all the additions to the Christmas menu, the Christmas dinner is only about fifteen cents more than the average dinners.

Another states that its per capita cost for December in 1930 was only two mills higher than the previous month. Even if it had been more, she says, it would have been well worth while.

Another hospital gives an increase in per capita cost of four cents for the Christmas week more than was spent for food for several weeks before.

Miss McFarland of Seaside Hospital gives a detailed explanation of the cost of the hospital's rather elaborate Christmas celebration. She states that the food cost for the breakfast tray was the same as any other day, and that the evening meal was slightly less, bringing the total increase in the patient's food costs for the day to four cents



a tray. The cost of the tree decorations, which includes the breakfast wreath, the greeting card, the nut cup and the Santa Claus is given as twelve and three-quarter cents. Added to the extra food cost of four cents, this makes a total increase for the day of sixteen and three-quarter cents a tray. The dining room decorations were eighteen cents a table and the extra food cost for each person in the dining room was six cents. For the entire hospital of 300 beds, she gives the figures for the

cost of decorations and the increased cost of food as follows:

	<i>Patient</i>	<i>Dining Room</i>
Food	\$12.00	\$10.50
Decorations	38.25	3.96

Still another hospital reports that the average increase per plate for the month of December over the previous month was five mills. Miss Anderson makes a point of saying that it is possible to serve a number of less expensive dishes during the month to justify the additional expense on Christmas.

Hospital Christmas Abroad

Letters from four foreign countries describe the Christmas customs in those countries.

Helen M. Pond, St. Luke's International Medical Center, Tokyo, Japan, in describing the Christmas celebration in Japan and the unusual menus, reveals the extent of American influence in the Orient.

"In Japan, Christmas is not celebrated as a festival, but New Year's Day is. In our hospital, which is a Christian institution, we always have a service in the chapel, which is attended by all of the staff and any of the patients who can go. Last year this was held on December 23 because the bishop could come on that night only. After the service, the nurses gave a Christmas play in the recreation hall. All the neighboring children crowded into the hall, until there was hardly any room for our own staff.

"Then on December 24 at noon we had our Christmas dinner for the staff. We had roast turkey last year, since it was cheap and we could afford it. This was the menu used:

Chicken Soup (clear, flavored with a spicy vegetable called mitsuba, and a kind of citrus fruit called uzu)
 Roast Turkey Potatoes
 Spinach with Peanut Sauce
 Black Beans and Chestnuts (cooked in syrup)
 Sweet Egg Roll
 Pickles Rice
 Mikons (Japanese Orange)

"The dining room was decorated in Christmas colors, poinsettias and red berries being used plentifully. The wards are always decorated with Christmas trees, and the nurses trim the halls with colored paper, festive pine and bamboo branches. With each ward trying to outdo the others, they are always pretty and gay.

"The children's ward is decorated by a committee of women from the various embassies, and many gifts of toys are distributed.

"On Christmas Eve we have a midnight service at the American Church to which we (the foreign staff) always go. On Christmas morning at five o'clock the nurses go through the wards of the hospital singing Christmas carols, afterwards coming to the houses of the foreign staff. The principal of the training school always serves cocoa when the nurses arrive at her house. It is a pretty sight to see them all (about fifty nurses) in the first faint light of dawn coming across the garden, each carrying a lantern.

"At six o'clock we all go to early service and communion in the hospital chapel. Usually we have few patients in the hospital at this time, since the preparation for New Year's has begun in all the Japanese homes and everybody who can do so goes home. On Christmas morning we always have name cards and holly on the trays. At noon we have a special dinner for any patients who are permitted to have it.

"When I first came to Tokyo eight years ago, there was little of the Christmas spirit in the city, but since then the department stores have begun to decorate with Christmas colors for their New Year's trade. As a result we have a whole month of perfectly beautiful stores and streets, which lasts until December 31.

"The first seven days of the New Year are all holidays. Some of the stores are open one or two days during this time, but everybody goes calling and all celebrate in their homes. It is a gay time. The streets and houses are decorated with pine branches and bamboo fronds hung with straw rope on which are fastened paper prayers. Then strings of colored lights or gay lanterns are used too. It is a beautiful sight. At New Year's time our nurses are given two days' holiday sometime during the holiday season. Gifts are exchanged at New Year's as at our Christmas time. Since the tradespeople try to pay all of their bills by January 1, December 31 is a busy day."

Where the Pudding Flames

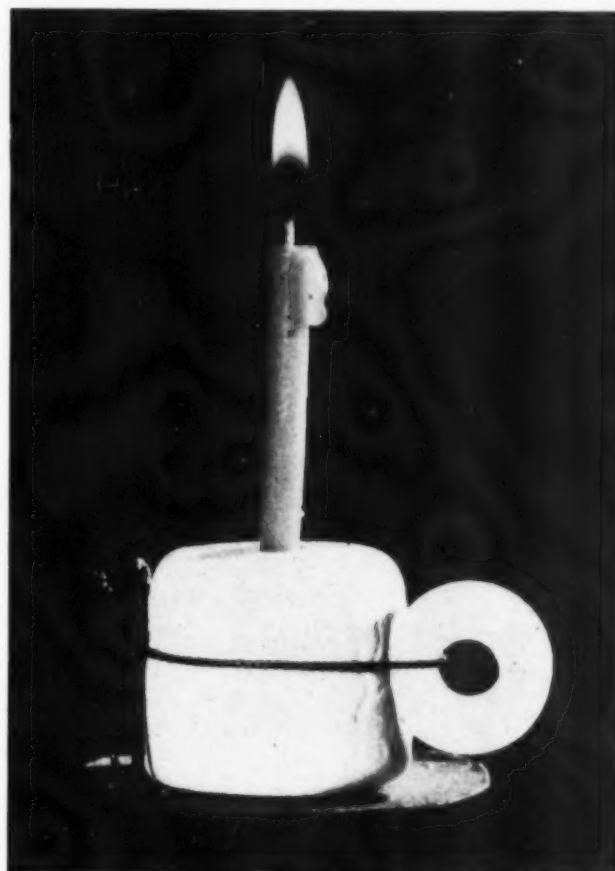
Anna Buchan, Royal Infirmary, Edinburgh, Scotland, who is in the United States on a Rockefeller Foundation fellowship, describes Christmas in her hospital. The part played by the doctor and the staff in the carving and serving of the trays is interesting. Worthy of special mention is the Christmas pudding served. She writes:

"In our hospital we try to make Christmas Day as pleasant as possible for the patient. Parties and concerts are arranged, and special attention is given to the menu.

"To the ordinary breakfast (porridge, tea, bread and butter) are added bacon and eggs.

"At dinner, each ward has its own pet plan, a

usual one being to set all trays on a large center table in the ward instead of in the kitchen. The trays are given a festive air with decorative paper tray cloths and on some are cardboard name cards in the form of Christmas trees. The roast turkey is carved here and served with its accessories, the doctors and staff serving and carrying the trays. Then comes the Christmas pudding



(steamed pudding with lots of currants and raisins, and a sprinkling of rings and buttons). This is carried in with its circle of flames (brandy poured around and lighted immediately before serving). Orange and scarlet crackers are placed on the trays to add color.

"At tea time plates of sweet cakes and biscuits are passed around, and no limit is put on the patient's rations. Of course, many patients are unable to indulge in all of these good things. Their trays are made as attractive as possible, special study being made of the diabetic diets. Different colored jellies are made, and a special cream pop-over is prepared for the diabetic's tea so that he may feel that he too is 'having cake'."

In Beirut, Syria, at the American University Hospital, Christmas must be an exciting day, or as one might say, season, because, as Henderika J. Rynbergen, in telling of Christmas in a country that is primarily Moslem explains, there are actu-

ally three Christmases—that of the Roman Catholic Church December 25, that of the Armenian Church a week later and that of the Greek Orthodox Church still a week later. There Christmas seems to many merely an interesting custom of other religions.

Festivities in Syria and Porto Rico

She further tells us of the varied duties and describes some of the activities, including the usual reactions of the staff, after it is all over. "On Christmas Day we celebrate by serving the best liked food of the country—in the case of Syria a dish called 'Kib-be.' It is made of ground meat pounded for hours with a crushed whole wheat. It is then rolled very thin, spread with pine nuts and fried onions, covered with another layer of meat and cracked wheat and baked. It is served with artificially soured milk and is delicious.

"We make no attempt to decorate the trays other than with colored bags of candy and oranges, as it is impossible to obtain Christmas decorations of the sort we get at home, and there is really no time to make them because the hospital is too large.

"There is, of course, a party for the nurses, with the lighting of the tree, the Christmas story and carols. The university is not a missionary institution, and there is no attempt to proselyte, but we like to carry on our own customs, especially at a time like Christmas, and the girls seem to enjoy it thoroughly. It helps to teach them tolerance, something sadly needed out here in this country of many religions."

One can realize how much effort it takes to prepare for such a Christmas when there is only one trained dietitian in a 175-bed hospital, who has complete charge of the department, including the teaching of nurses. As she tells of her work and of her joy in it she leaves with us an interesting picture of Syria, "with the blue Mediterranean at our doorstep and the Lebanon starting in our back yard."

Alice E. Miller, dietitian, Presbyterian Hospital, San Juan, Porto Rico, interestingly describes the Christmas customs in that country. Unfortunately it does not deal to any great extent with the hospital, but it presents so vivid a picture of Christmas and the celebration that takes place on December 24 that we are able to visualize how different Christmas in a hospital would be in Porto Rico, especially with the unusual foods used.

"'Noche Buena' which means 'the good night' is celebrated on the evening of December 24 by a party which begins early in the evening with dancing and games. The merrymaking halts long

enough for the guests to go to mass at the cathedral at eleven o'clock. The brilliantly lighted cathedrals in all of the towns radiate joy and gladness. The many crystals on the candelabra reflect the glowing and dimming of the candlelight. The scent of asucenas (a tuberose) and roses greets the worshiper before he enters the church. All doors and windows are open, for it is warm in Porto Rico on Christmas Eve. The women wear evening gowns and a mantilla and carry only a fan.

"Each altar of the cathedral is covered with from one to three altar cloths of exquisite crocheting, embroidery or colado (a combination of drawn work and weaving done with needle and thread on either Spanish or Irish linen). When the services have ended the party reunites and continues with a supper at midnight.

"Soup is served first, then broiled young pig, rice with turkey, baked ham, 'pasteles' (made of a kind of green banana boiled and mashed, chick peas, raisins, olives, ripe mango peppers, wrapped in a green banana leaf to the size of a business envelope, tied well and boiled three hours), green plantanoes (sliced, fried, pressed flat and fried again), oranges, apples, candies imported from Spain and those made from cocoanut, guava, mango, grapefruit, orange or green papaya.

"The members of the party go home in the morning to spend the day of December 25 sleeping.

"Until the American occupation gifts were not given at 'Noche Buena' but at Three Kings' Days, which were celebrated on January 6, 7 and 8."

Thus we have seen Christmas in America and abroad. Although custom has varied the celebration of Christmas, the Christian spirit of Christmas has been carried round the world.

Photographs Add Rare Human Touch to This Hospital Report

The Merseyside Hospitals Council, Liverpool, England, has issued its third annual report and presents by means of well chosen words, artistic photographs and carefully prepared diagrams, charts and tables the work of the hospitals and their needs. The photographs especially are worthy of special mention. F. W. C. Hollett and Harold Brown, Liverpool, and Dr. Max Thorek, Chicago, cooperated in illustrating the report. They have added a rare human touch to a document necessarily consisting mainly of facts and figures. In fact the entire format of the report could well be emulated.

A Linen Control System That Saves Time and Money

NURSES have no responsibility in connection with the handling of linen supplies in a newly established laundry and linen service at the Children's Memorial Hospital, Chicago. They do not need to make requisitions or to count soiled linen. Their time and energy are conserved for professional duties.

This is only one of several features of the service that interested Chicago hospital administrators in paying a visit to this laundry. In fact, a part of the program of the November meeting of the Chicago Hospital Association was a tour of the newly installed laundry plant at Children's Memorial.

Linen is one of the hospital's most important tools. Its successful handling is 10 per cent laundry and 90 per cent linen control. Control at this institution is coordinated under a single head and the entire staff comprises twenty persons. Every worker is also a linen inspector. If it is noticed that any article is in need of repair it is up to the

worker to dispatch it immediately to the sewing department.

Careful inventory has been made of the number of articles of each type required to serve each floor and department; that amount is automatically supplied by the linen department. Four sets of each article are provided—one is in use, one is in reserve on the floor, one is in the storage room and one is in the process of being laundered. In all 33,000 pieces of linen are in circulation in the hospital.

Articles are classified according to type—sheets, pillowcases, towels and so forth—and each type has a serial number. This is the sole classification.

New linen is immediately marked with the serial number in indelible ink, along with the name of the hospital. This is done in the linen room, a nice light room on the ground floor. Here are plenty of large tables where articles are sorted



All sheets and large pieces of flatwork are ironed in the flatwork ironer, which is installed in a well lighted corner of the ironing room.



In this corner of the ironing room smaller articles are pressed, and the sewer seen in the foreground makes the necessary repairs.

as to kind. After sorting they are placed on shelves and in bins, an abundance of which are provided for this purpose. In this room all new supplies are received, stored and reissued when necessary.

Four Preliminary Procedures

Linen is brought from the hospital to the laundry in canvas bags. In each bag a slip of paper records the number of pieces therein. Next the bag is weighed. The preliminary routine in handling con-

sists of four procedures: (1) the sorter looks for the serial number; (2) she makes a check opposite the corresponding number on her count sheet; (3) she trips the lever on her adding machine, and (4) she tosses the article among the pile ready for washing.

While the linens are in the washers they touch only the monel metal lining of the equipment. The water is softened by zeolites to the degree of softness of rain water. Modified soda, the highest



The wash room, illustrated here, is equipped with up-to-date laundry machinery. The overhead conveyor is shown at the far left.

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THE CHILDREN'S MEMORIAL HOSPITAL
CHICAGO, ILLINOIS

LAUNDRY DIVISION
FLAT and ROUGH DRY

Date _____

FLOOR	WARD	DEPARTMENT		Bag No.	WEIGHT	COUNTER	Counter Reading—Finish																								
		By:					Counter Reading—Start																								
							Pieces in Bag																								
11	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	121	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	131	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
12	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	141	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	151	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
13	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	162	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	171	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
14	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	181	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	182	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
15	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	183	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	191	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
21	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	192	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
22	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
31	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15

The serial numbers on the count sheet are staggered so that they may be more quickly read. Each serial number represents a certain type of article. The information on the count sheet is summarized and entered on the summary sheet.

grade of soap flakes, bleach and water make up the washing solution. The soap formula used consists of twenty pounds of soap flakes, twenty pounds of soda and three pounds of trisodium phosphate. After the washing process is completed an overhead conveyor takes the goods to the extractors.

Fabrics thus gently treated pass on into the fully equipped ironing room. On the eight-roll flatwork ironer is a device that collects static electricity and prevents shocks to the workers. A blanket drying machine is in constant work. Modern devices control the ironing presses so that no scorching may occur, even if the linens were left in place for four hours. Hand ironing gives the finishing touches to garments from the presses.

An interesting piece of equipment is the handkerchief net. No person's handkerchiefs, by this method of handling, are permitted to come in contact with the handkerchiefs of others.

The new laundry building, adjacent to a new power plant, is a compact three-story brick structure on the northwest corner of the hospital grounds. It is above street level and thus the operators have full advantage of abundant sunlight and ventilation. Arrangement of machinery has been carefully planned so as to permit ease of handling and orderly operation.

An experienced consultant has installed in the

plant numerous timesaving, laborsaving and economical methods. At the same time the standard of work done is said to have been considerably raised in comparison with the work done in the old laundry, recently wrecked to make room for a seven-story nurses' home. The appearance of the linen has improved notably.

How Forty-Two Physicians Serve Patients in a County Hospital

Physicians of the Champaign County Academy of Medicine, Champaign, Ill., have built up a system of medical care at the county hospital that assures to needy persons of the county excellent first-class treatment for their ills, according to the *Champaign News-Gazette*.

The system takes advantage of the skill of forty-two physicians of both Champaign and Urbana, Ill., who are members of the academy. It is one that allows a patient of the county freedom in the selection of his physician.

At the bimonthly meetings of the academy, a team of physicians to take care of the patients at the hospital for a two-month period is appointed and a clinic is held on the unusual cases that have been handled during the past two-month period.

Practical Administrative Problems:

Preparing the Patient for an Operation

MUCH has been written and spoken relative to the need for standardization of many hospital procedures. Such a step presents no disturbing theoretical difficulties. Practically, however, when we undertake to classify the manifold and diversified steps by which the daily work of the hospital is accomplished, we encounter many difficulties, some apparently insurmountable.

Perhaps the greatest difficulty that is met is the factor of the surgeons' personal opinion relative to the efficacy of some single drug or procedure. To cull the wheat of truth and proved worth from the straw of fallacious belief of the individual is difficult. Medicine is far from being an exact science. Nevertheless it should be possible, perhaps, to arrive at some minimum standard of practice generally applicable throughout the field. Once this has been accomplished, many of the technical procedures daily practiced in the institution could be made to conform to this grouping.

In the last issue of THE MODERN HOSPITAL there appeared some introductory remarks bearing on this subject. It was stated generally that the chief purpose of any such attempt was to save the time of physicians, nurses and other members of the hospital's personnel, and by so doing to bring about economy in administration and thus direct benefit to the patient.

How Time Economies Can Be Effected

The truth of the first statement is not difficult to demonstrate. Indeed, it is almost self-evident that if nurses are required to learn fewer methods of carrying on their work and hence of accomplishing any particular end, less time and effort are involved and a great simplification of cerebral and physical processes will surely result. Moreover, if such a codification could be accomplished much less chance of error would no doubt exist and at the same time, more patients could be cared for with the same expenditure of time.

Since approximately 50 per cent of a hospital's funds is required for the salaries of its personnel, it is also self-evident that an economy in time is represented by a direct saving in money and hence, fewer nurses, orderlies and maids would be re-

quired to provide the same amount of care. If because of a codification of hospital procedures there is less chance of serious error in the work of the nurse and if the institution can be saved money thereby, all things else being equal, the patient must receive more efficient care. It should be remarked here that the presence of a multiplicity of standing orders does not represent in any true sense a helpful standardization of technique. Standing orders, unless they are acceptable to and practiced by the surgeon group as a whole accomplish little good. Indeed, in permitting the existence of rough and unclassified standing orders, the executive subjects the patient to the very real possibility of mistakes occurring both in technique and in therapeutics. If every surgeon in the hospital is permitted to prepare and insist upon the observance of a complicated system of standing orders, nothing but confusion can result among those responsible for carrying out such orders.

Data Are Based on Questionnaire

Enough has been said, however, in review and support of the need for standardization generally. It shall be the purpose of this sketch to describe the present status of this matter in the surgical and operating room departments of the hospital field as a whole. In addition, an attempt will be made to describe current trends as observed in the practice of preoperative, operative and postoperative technique in a group of representative institutions of all sizes.

In order to secure first-hand evidence concerning the methods being employed throughout the hospital field, the following questionnaire was sent to 120 institutions:

1. Do you use sterile water or saline solution in your operating room in hand basins and for moistening sponges?
Where and by whom is sterile water prepared for general use about your hospital?
2. How do you sterilize dressings?
Time and pressure employed?
Do you use some form of thermometric control?
Do you rely on steam gauges?

3. How do you sterilize instruments?
Boiling water?
Do you use soda or other chemicals in water?
If so, which and what quantity?
How long do you boil them?
How do you sterilize such special instruments as scalpels, eye knives, bronchoscopic instruments?
4. How do you sterilize rubber gloves?
Boiling water?
Autoclave?
Do you have any special method of sterilizing the inside surfaces of gloves?
5. How do your surgeons prepare the skin of the patient before operation?
Ward preparation
Operating room preparation

In the selection of the hospitals to which these questionnaires were sent, a serious attempt was made to obtain the opinions of the staff and superintendents of a true cross section of the field. Consequently, approximately 20 per cent of these forms were sent to institutions of 400 beds and over; 20 per cent to those between 200 and 400; 20 per cent to those between 100 and 200, and the remainder to those of less than 100 beds. That the institutional field is interested in learning some better method of carrying on its surgical and operating room work, as far as it affects the standardization of such routine steps as the preparation of the patient in the ward and in the operating room and the carrying out of his treatment after the surgical procedure is completed, is demonstrated by the fact that ninety-five or 79 per cent of the group promptly replied to the questionnaire, a splendid showing.

Are Individual Preferences Justifiable?

And yet the mere fact that a large number of carefully compiled institutional replies were promptly received does not entirely reach the root of the matter. In the perusal of the answers to these questionnaires, it was quickly observed that few institutions could speak as a unit and that in some of the cases it was necessary to set down qualifications in regard to the individual preferences of the members of the surgical staffs. This fact, instead of being discouraging, is but added evidence of the need for such a study.

Perhaps at some future date through the offices of some national surgical or medical association it may be possible to learn from the individual surgeon himself his preference and the reasons for his preference as to technique, the antiseptic to be employed in skin sterilization and the many other details of ward and operating work if an attempt at standardization through the efforts of the ad-

ministrator of the institution fails. And yet if the superintendent of the hospital is fully convinced of the necessity for such an effort, the result will be more rapidly brought about than if an effort were made to convince the individual surgeon of the necessity for this step.

The preoperative preparation of the patient is a matter of vital interest to the patient himself as well as to the institution in which he is being treated. It cannot be too strongly stressed that too many patients are brought to the operating table with indecent haste and that a shortening of the period of disability and even the saving of life can sometimes be accomplished by more thorough preoperative study. Particular reference is here made to the necessity for a precise evaluation of the functional capacity of the heart, kidney, liver and other vital organs. A carefully formulated diagnosis before operation is undertaken is nothing if not life-saving. There can be no greater fallacy than that held by some surgeons who proclaim the wisdom of making the operation perform two functions, that of diagnosis and treatment.

Hasty Surgery Should Be Avoided

But this sketch does not concern itself with an attempt to outline the diagnostic and precautionary steps necessary for the welfare of the patient before surgery is undertaken. It does particularly bear, however, upon the physical technique of preparing an individual for a serious surgical procedure once the diagnosis has been made. By the same token, however, the hospital should forcefully demand that unnecessary and hasty surgery be forbidden within its walls. The question of regulating the thoughts and actions of the members of the surgical group presents far more serious difficulties than does that which concerns itself with the codification of the mere physical steps necessary for preoperative preparation.

It has not been proved that the more complicated the process of preparing a field of operation for surgical intervention, the safer is the procedure for the patient. Unduly complicated and lengthy techniques are not only fatiguing for the patient and time consuming for the nurse but often present no proved virtues. Indeed, frequently the simpler and more rational the technique, the better are the results obtained. Preoperative preparation includes in many instances the administration of protective and sedative drugs, and in liver surgery, for instance, certain solutions such as saline or glucose are frequently used intravenously. The mechanical preparation, however, usually consists of shaving and scrubbing the operative field and employing one or more of a group of more or less tried and true antiseptics. The most popular

chemicals employed to sterilize the skin are iodine, alcohol, ether, mercurochrome, picric acid, occasionally bichloride of mercury, acriflavine and metaphen. It is surprising to the investigator to learn the great variation of combinations that may be employed by the use of one or more of this small group of antiseptic agents. Moreover, there is a great variation of opinion throughout the field as to whether the major portion of the preparation of the patient should be carried out in the ward or in the operating room.

Ward Versus Operating Room Technique

As a general rule, there appears to be an inverse proportion between the simplicity of ward and operating room techniques, that is, the simpler the ward technique, the more complicated the operating room procedures. This is, of course, what one would expect. On the other hand, in many institutions the same steps are carried out in both the ward and the operating room. For example, in some cases, shaving, scrubbing and sterilizing the skin of the abdomen by the use of antiseptics is thoroughly performed both in the ward and in the operating room.

A compilation of the answers to the questionnaire revealed the following information:

Fifteen or 16 per cent of the hospitals stated that their patients are prepared in the ward by shaving, cleansing the field with green soap and water, and applying sterile dressings. Sixteen per cent stated that the field of operation is scrubbed with soap and water, shaved, and then ether and alcohol is applied, followed by sterile dressings. Eleven or 12 per cent reported that the field of operation is shaved, scrubbed with soap and water, and then alcohol is applied.

How Ward Techniques Vary

Almost every hospital reporting, in which ward preparation is practiced, stated that the field of operation is shaved and scrubbed with soap and water. In a few instances, no soap and water are employed but the patient's skin is dry shaved.

There is great variation in the choice of the antiseptic to be employed in ward technique. In 2 instances, benzene was substituted for ether, before the use of alcohol. In 8 instances, or approximately 7 per cent, ether, alcohol and iodine were employed. In one instance, ether, alcohol and 2.5 per cent picric acid were used. In one instance merely an alcohol pack was employed, and in another case, bichloride of mercury 1-1,000. In one, ether and alcohol, and 10 per cent mercurochrome were used, in another, after shaving, 2 per cent mercurochrome was used. In still another, one of the following—alcohol, bichloride, an alcohol-phenoco-

acetone solution, picric acid or iodine and alcohol was used. The last institution offers a splendid example of the confusion that results when each surgeon is permitted to employ an entirely different type of preoperative preparation of the skin. In 2 hospitals, gasoline, ether and 7.5 per cent iodine or 5 per cent picric acid were applied following the shaving and scrubbing of the skin. In 3 hospitals, only alcohol was used. In 5 shaving only was performed. In another, 50 per cent alcohol or mercurochrome and 2 per cent acetone were used to sterilize the skin. In 2 hospitals after shaving the skin was scrubbed with green soap and ether applied. Four employed alcohol and 2 per cent iodine. Two stated that no ward preparation was carried out. One employed benzene and alcohol, and one bichloride and iodine. One used 3.5 per cent iodine and one 10 per cent iodine.

Choosing the Antiseptic

It will be seen from the foregoing statements that the great variation in the actual preparation of the patient's skin prior to operation is largely concerned with the choice of the antiseptic, and in many instances, only with the strength of the solution of the chemical employed. Surely it should be easy to determine by laboratory methods whether a 5 per cent solution of picric acid possesses any advantages over one of 2.5 per cent strength. Moreover, it certainly should be possible to estimate whether the patient's chances of suffering an infection are minimized by the use of a 7.5 per cent solution of iodine rather than one of 3 per cent concentration. In many institutions, 95 per cent alcohol is employed. In others, 70 per cent alcohol is thought to be effective. Indeed, it has been stated by reliable chemists that the bactericidal activity of alcohol is at its maximum at 70 per cent concentration. One may draw from the foregoing statements, therefore, certain conclusions as to current trends. The following figures set forth the frequency with which the various antiseptics and solvents are employed by the 95 hospitals answering the questionnaire: alcohol, 51; iodine, 20; ether, 30; mercurochrome, 8; picric acid, 4; benzene, 4; bichloride of mercury, 4; gasoline, 2.

In these figures it has been impossible to set down the first choice of the various hospitals from the standpoint of supposed reliability. This is the case because, as was stated earlier in this article, the drug employed frequently represents the choice of the individual surgeon and not of the group. One may rather safely conclude, however, that the majority of surgeons in the institutions answering the questionnaire believe iodine and alcohol to be the best antiseptics for sterilizing the operative field of the preoperative patient. Whenever alcohol

was employed, it was usually employed as a complement to the use of iodine. Those agents employed as solvents of skin surface fats, such as ether, acetone, gasoline and benzene, were frequently found to be a part of the preoperative ward technique in the sterilization of the skin. Picric acid in a 5 per cent solution apparently has considerable popularity.

Methods Usually Followed

A common practice also observed was the use of mercurochrome or iodine and alcohol in the operating room after the shaving and scrubbing of the skin in the ward. It may be said, therefore, that in the majority of instances, it is evidently considered the safest practice to carry out the following technique:

1. Shave and cleanse the skin of the operative area with green soap and water. This is done on the afternoon or evening prior to the day of operation.

2. Asepticize the operative area by the use of ether, iodine and alcohol or mercurochrome.

3. Apply sterile dressings.

The answers to the questionnaire setting forth the technique employed in the operating room, as far as the preparation of the field is concerned, revealed a greater variety of opinion than those expressed in regard to the necessities of ward preparation.

In 23 or 24 per cent of the hospitals replying, iodine and alcohol were employed to sterilize the skin. In 14 or 15 per cent, 3.5 per cent iodine alone was used. In 12 or 12 per cent, ether, 70 per cent alcohol and 4 per cent iodine were employed. In 4, benzene, ether, iodine and alcohol were used. In 4 instances, ether, 70 per cent alcohol and 5 per cent picric acid were used. In 4, mercurochrome was employed; in 3, ether and 3 per cent iodine, and in 3, ether and 2 per cent mercurochrome were used. In 2 each, alcohol and picric acid, acetone and alcohol and ether and picric acid were employed.

There were many isolated instances in which various combinations of the chemicals mentioned were thought more safe. For example, in one institution the skin after being asepticized was painted with collodion. Acriflavine was employed in one instance; picric acid and alcohol in one; ether, picric acid and mercurochrome in one; alcohol-phenoco-acetone solution in one; ether and Scott's solution in one; 10 per cent alcoholic solution of mercurochrome in one. In other instances, benzol and iodine, mercurochrome and alcohol, alcohol and bichloride 1-1,000 and metaphen were reported as used. Doubtless many other combinations or single drugs are employed in operat-

ing room technique throughout the hospital field.

The experiences of hospitals as reflected in the replies to this questionnaire seem to imply a greater variation of techniques in the use of asepticizing agents in the operating room as compared with the ward. Perhaps this observation is a natural one, since most surgeons rely almost entirely upon operating room preparation in guarding against infection.

The following figures show the relative frequency with which the drugs employed as antiseptics are used in the operating room sterilization of the surgical field by the hospitals interrogated: iodine, 79; alcohol, 73; ether, 48; mercurochrome, 22; picric acid, 18; benzene, 10; acetone, 2 per cent, 5; bichloride of mercury, 3; acriflavine, 2; metaphen, 2.

These figures are to be interpreted as setting forth the frequency with which any individual chemical was employed and do not signify that in the number of instances cited this was the only drug used to sterilize the skin.

The same trends are noted in these figures as were observed in the figures listing the drugs used in preoperative preparation. Mercurochrome is more frequently used in the operating room than in the wards, however, and one observes the use of fat solvents with relatively greater frequency in the operating room than in the wards. Bichloride of mercury seems to be little used, and acriflavine and metaphen have not as yet gained a foothold.

A Composite Technique

It seems, therefore, that the surgeons in the majority of hospitals studied prefer the application of a chemical antiseptic as a major portion of the final technique in sterilizing the skin of the operative field, and that scrubbing with water and green soap is rarely done in the operating room. If a composite of the techniques outlined above were to be set down, it would approximate the following: paint the abdomen with 3.5 per cent iodine, followed by the application of 70 per cent alcohol; or use ether, 4 per cent iodine and 70 per cent alcohol, or employ a 2 per cent solution of mercurochrome (in some instances, a 10 per cent alcoholic solution was employed).

Since all the chemicals mentioned are definitely germicidal, it is not beyond the bounds of reason to suppose that a standardization of technique covering the preparation of the operation field could be safely and successfully sought.

In the next issue of THE MODERN HOSPITAL will be set forth the facts revealed by the questionnaire as they relate to the sterilization of water, dressings, instruments and rubber gloves.

Editorials



California's Venture in Sickness Insurance

THE article by Michael M. Davis in this issue of THE MODERN HOSPITAL calls attention to some of the efforts being made in this country to solve the economic aspects of medical care. All leading countries of the world have attempted to distribute the uneven burden of sickness and disability, usually through some form of sickness insurance. There is a growing sentiment that we shall have to meet our responsibilities in this field also, possibly by methods adapted particularly to conditions and needs in this country.

The efforts in California illustrate the wide variety of methods now being tried in every section of the country. Industrial medical services of different types exist in many places now. Some cover medical care for the families of the employed persons. Medical services in schools and colleges are other illustrations and are extending rapidly. Group life insurance now written to cover over ten billion dollars worth of insurance is a possible vehicle for sickness insurance.

A number of medical societies have entered into contracts with local governments to provide medical care for those of the community who are unable to pay private medical fees. Lodge medical practice and sickness benefit associations are common everywhere. The Federal Government is extending medical practice into civil life through such agencies as the Veterans' Bureau. State governments are doing likewise through the activities of the health departments. Hospital and private groups of physicians, health and hospital associations, labor unions and other groups are endeavoring to meet different aspects of the problem. Clinics of private and public hospitals provide medical care in the cities for the same elements in the population as are served by sickness insurance abroad.

There is considerable collective medical practice already in existence in this country through industrial medicine, contract practice, medical corporations (group practice, clinics, hospitals) and a beginning of sickness insurance.

These developments are evidence of the growing tendency to adapt medical services to changing conditions and demands in the community and in the profession. Most of the efforts thus far have been

voluntary and local, but it is significant that state legislative commissions in nine states have already studied and reported on compulsory sickness insurance. These efforts are similar to the varied voluntary arrangements and contract practice in Great Britain before the passage of the National Health Insurance Act of 1911 and the voluntary insurance funds in other European countries, some of which physicians created and manage.

In most European countries, the present compulsory schemes of sickness insurance were imposed on previous schemes of voluntary, mutual insurance programs. In the European programs, the governments have a large voice in the administration of the programs and make large financial contributions to them. These developments have inevitably introduced political factors in the management of sickness insurance everywhere.

The problems presented by the newer demands and conditions of medical practice and the clearer recognition of the value of health and proper medical care for the entire population require changes in the form and methods of medical practice. They challenge the most thoughtful consideration of the hospital, and of the nursing and medical professions and demand the highest leadership if these new and larger responsibilities to society are to be met satisfactorily. It appears to be inevitable that economic changes in hospital and medical practice will occur and it is a hopeful sign that the medical profession is alive to the situation and that efforts are being made to meet and direct the new demands.

Mr. Davis has done a good service in reporting the efforts in California to deal with the economic problems of medical care. His article is timely and provocative.

My Friend's Friend

IN MANY hospitals for the acutely ill are to be found aged and chronically diseased patients who have occupied much needed medical or surgical beds for many months. The folly of adopting a policy that clogs hospital services for the acutely ill is obvious to all; yet the superintendent vainly, even if at times feebly, strives to obtain the transfer of these persons to less expensive and more suitable quarters.

Often the admission of chronically ill patients is brought about through the offices of a board member or of someone socially or politically prominent in the community. In most instances it is enough for the friend to be several friends removed from the person making the request. The superintendent cannot afford (so it is thought) to make

any enemies for himself or his hospital. The politician considers the accession to such a request to represent a *quid pro quo* for the casting of his vote in favor of frequently meager and inadequate appropriation for the hospital. The board member or bank president does not look beyond the immediate gratification he receives from performing a service to some one of his acquaintances. To some it is pain to say "no."

When each hospital bed does not serve its allotted two patients a month, the community is being unjustly deprived of its due. The chronically ill and the acutely ill, moreover, do not mingle well, and hospitals for the one are neither suitable nor necessary for the other. To admit such unsuitable patients is easy while to obtain their discharge is difficult. If the politician or the socially prominent person desires ward service for the chronically ill patient, let him pay for it. In the face of such a proposition, the zeal of either will be likely to cool quickly and as a result the hospital will be spared much irritation and difficulty.

Names That Need Changing

MEMBERS of the profession of administrative medicine, like their colleagues in clinical medicine, often subject themselves to the accusation of callousness in the pursuit of their specialty.

One of the justifications of this accusation is the tendency to call a spade a spade when the English language contains designations that are more euphemistic and less aggravating to the sick and to those who are more intimately concerned about them. Thus, we have the hospital or sanatorium "for consumptives," "cancer" wards, "homes for incurables," "insane asylums," "charity" hospitals. It has been suggested that these designations are usually made by men who work at the desk rather than at the bedside and that greater consideration could be shown for the feelings of patients and their friends if the governing authorities and the administration of the hospital would spend a little more time studying the more intimate psychology of those whom they have been appointed or elected to serve. In some persons continuous contact with the sick dulls the edge of sympathy and breeds disrespect for their rights. It is not always borne in mind that the true humanitarian is he who never becomes reconciled to suffering.

The term, "home for incurables," strikes not only at the patient and his friends, but is a reflection on the science of medicine, for who shall say when a patient is beyond all possible means of medical help? Some of the incurable patients of

yesterday are the curable patients of to-day and it is therefore reasonable to expect that some of the incurable patients of to-day will be the curable patients of to-morrow. This cannot, however, be encouraged if we continue to segregate, isolate and forget them in "homes for incurables." Selective interest on the part of our medical men of science who in the past have made life saving or life prolonging inventions and discoveries when others have given up hope is one possibility. The term itself is presumptuous because it creates an atmosphere of finality about the inmate and gives the impression that the medical and social agents have passed a life sentence and in some cases a sentence of death, that may not be appealed. The hospital "for chronic diseases," if the hospital must be identified in detail—scientifically a more accurate designation—has the merit of hopefulness which the "home for incurables" lacks.

It should be obvious that a "consumptive" is better off spiritually as well as physically in a ward that specializes in "diseases of the chest" or in a sanatorium that has no special designation, than he is in a place where he is constantly reminded on every hand of the consuming power of his disease which the designation would seem to convey as uniformly inevitable.

The "department of social welfare" has far more to recommend it than the "department of charities," for one of the great advances made in our civilization during this generation has been the recognition that the recipient of relief in any form is entirely within his rights and privileges, and that the donor of such relief, whether government or voluntary, is in honor bound to provide it as generously, as gracefully and as sympathetically as the English language (at least) makes possible.

The Sick Poor

MOST hospitals justify the continuance of their existence and were indeed begotten in a noble desire to serve "the sick poor." On this point, private (voluntary) and public (government) hospitals are in harmony and financial support flows from self-imposed as well as compulsory taxation.

With the passage of time however, new scientific and social discoveries were made and it is now generally established that hospitals in serving the sick thereby provide additional protection to the health of the public, for no section of a community can long boast of a high record of health when another section is left to incubate disease and to propagate it among its more fortunate neighbors. Thus an-

other phase of the preventive medical function of the modern hospital comes to be recognized along with its curative, educational and research functions, and the patient is treated not only for his own sake but for the sake of the community in which he lives.

In circumstances like these, it might be fairly asked whether those patients whom the older hospitals condescendingly referred to as the "sick poor" (as many still do) are not entitled to hospital care as their right and privilege. If, as one of the pioneers of the public health movement in New York State pointed out long ago, public health is purchasable within reasonable limits and if we are to accept the practice of our civilization in taxing the more fortunate in favor of the less fortunate as an obligation the community owes to its component parts, it follows that the benefits of hospital service should be distributed by "each according to his ability to each according to his need," as some of our contemporary political thinkers express it.

The sick poor (a designation that should be abandoned if the English language affords a better and less condescending term) particularly in times like these, have the right and privilege to expect a courteous and sympathetic welcome when they knock at our doors for relief. The hospital that would make economies in operation and reduce its deficit at the expense of the less fortunate by a policy of exclusion or limitation has failed of its fundamental purposes.

Children Visitors

AS SOON as disease begins to wane the ailing mother in the hospital longs to see her children. The father may yearn to look again upon his first-born of still tender years and the convalescing child may ask for his brothers or sisters. But the effect on the child himself as a result of a visit to the hospital is not always salutary and certainly hospital corridors and rooms are hardly appropriate for romping and noisy children. Moreover, the possibility of contagion being spread by children incubating the acute exanthemata is always present. Difficult as such a task is, the hospital should strenuously endeavor to prevent visits to and by children who are under the age of ten years.

Perhaps a playroom in which visiting children may be entertained while their parents are visiting the sick is indicated. Possibly the community can be made to understand the sanity of such a rule. Whatever the expedient adopted, it must be based on the principle of accomplishing the greatest

safety to the greatest number. Too ready acquiescence to requests for permission for children to visit the hospital is certainly kind neither to the visitor nor the visited.

Contributions From the Personnel

MANY hospitals during the past years have convinced themselves that it has been necessary to reduce salaries from 5 to 20 per cent. Some have done this in as painless a fashion as possible, while unfortunately others have arbitrarily sent forth the order for the reduction without much in the way of explanation. There has been a third division which has not disturbed the incomes of those who labor faithfully, good times and bad, for the success of the hospital that employs them.

The entire subject has been the topic of bitter controversy recently, with supporters of all positions offering their reasons. Out of these discussions has come a happy solution from a particularly able hospital administrator in New England. He has not as yet been forced to retrench but he feels that the possibility is close at hand and he is prepared for it. Rather than admit that the personnel were overpaid in good times and to avoid any appearance of exploitation in difficult times, he has devised a scheme which seems to us fairer than any yet advanced.

Instead of announcing a cut in salary of 10 per cent, this administrator is going to tell his assistants that until better times return they will be taxed 10 per cent of their wages which will serve as a donation to the hospital. When conditions warrant, the contribution from them will no longer be necessary, and they will return to the old schedules. In this way he will not destroy the esprit de corps that it has taken years to build up—rather, in many cases, he will increase this loyalty, for there are none so quick to see its justice as those who work in hospitals.

Wage cutting in hospitals when it is not absolutely necessary is a shortsighted and vicious practice. Never were hospital workers paid adequately and at this crucial time to reduce salaries because the administration knows full well the workers have no other place to turn to is a despicable trick that will disrupt service and accomplish no good. It is to the credit of most hospitals that no such nefarious practice has been indulged in, and hospitals as a class have been the last to ask their personnel to accept less pay. But it must be conceded that the New England administrator has shown himself more farsighted than many of his brethren in meeting a difficult situation.

Is Your Problem Answered Here?

SHOULD THE HOSPITAL PROVIDE DRUGS AND SERVICE TO STAFF DOCTORS AT COST?

It has been the experience of most hospitals that when the loyalty of the visiting staff is maintained at a high degree a greater scientific and financial return is secured. There is no reason why a hospital should not be of service in as great a way as possible to the members of its staff. To save these physicians money in providing at cost supplies for use in their offices is inexpensive to the hospital and usually represents a policy much appreciated by the physician. Indeed, this plan often includes providing free service to staff members when they become ill and in a few instances a reduced rate is granted to members of their family. The degree to which the latter plan is pursued depends somewhat upon the size of the hospital and the adequacy of its private room facilities. Certainly some reduction should be made in hospital charges to the sick staff physician even if he is not given totally free care. THE MODERN HOSPITAL commends those institutions that are financially able to offer to their staff such perquisites, and advises, both from the standpoint of the elevation of morale and from the increase of hospital income, the adoption of liberal financial policies affecting its staff members.

IS THE HOSPITAL RESPONSIBLE FOR UNETHICAL ACTS OF ITS STAFF MEMBERS?

If a staff physician should behave in an unethical way toward his patients and his colleagues within the institution, the hospital surely should interfere. When a physician permits himself to behave in an unethical manner towards physicians generally in the community, the hospital is only indirectly interested. The so-called practice of "stealing patients" or of discussing the failings of his medical brothers or of being guilty of any of the other borderline faults of behavior are matters that do not particularly harm the hospital except by creating suspicion concerning the good judgment of the board of trustees in permitting such a physician to remain on duty.

Immoral acts on the part of the physician, whether within or without the hospital, immediately become matters that deeply concern the in-

stitution. No hospital should permit a man to remain as a member of its staff who is repeatedly unethical even in matters that do not affect the morale of the physician or of the community. A staff should reflect credit upon the hospital to which it is attached, and the board of directors has a perfect right to step in when such breaches of good practice reach a point at which either the reputation or the finances of the hospital is affected. In the broadest of terms, therefore, the hospital is in a measure responsible for the unethical acts by its staff.

SHOULD THE HOSPITAL PHARMACY SELL TO THE PUBLIC?

Much has been written in this and other magazines and comment has been made from hospital association platforms relative to the wisdom of the hospital pharmacy competing with commercial establishments. It is not possible in this short sketch to make any definite statements as to the wisdom, or lack of it, of adopting such a policy. Some institutions have so placed their pharmacies as to attract the patronage of those entering their lobbies or even of catching the attention of the casual passer-by.

There is no doubt that the hospital has a right to fill prescriptions originating in the out-patient department and to charge for them a reasonable sum. Return prescriptions from expatients may also be filled at the hospital pharmacy with propriety. Until the institution is able to meet competition as it exists outside the hospital and to expect to balance its accounts from its own earnings or from its legitimate resources, it should hesitate to enter into open competition.

The hospital should compare carefully the financial gain that accrues as a result of the conduct of its pharmacy with the loss in confidence and good feeling as well as in community contributions that sometimes follows when business men feel that the hospital is not playing fair with them. It is regrettable that the hospital must depend largely on public contributions, but since this is the case, it appears that until institutions can hope to make their incomes equal their expenditures, they should continue to dispense pharmaceuticals to their own clientele only.

HOW CAN ORDERLIES BE TAUGHT TO RESPECT THE FEELINGS OF VISITORS?

Recently in a high grade hospital, a nervous visitor, a woman, was required to ride in an elevator with the body of a patient who had just died. This woman naturally was shocked by such an experience and concluded that this was but one of the minor evidences of a greater and more serious mismanagement that was taking place in this institution. No more regrettable incident could have occurred in this hospital, since the visitor represented a wealthy and charitably inclined family which had contemplated rather extensive benefactions to the institution.

This incident represents but one of many types of occurrences that disturb the peace of mind of the public and which create a distrust in the management and the humanitarian instincts of the hospital. Here a forty-dollar-a-month-orderly, because of lack of training, in a few minutes counteracted much of a visitor's hitherto good impression of the institution which had taken many months on the part of an earnest administrator to build up.

It is incomprehensible to a lay public how a hospital can employ such uncouth, ignorant and careless help. Moreover, it may be said that the usual method, adopted by hospitals generally, is briefly to interview an applicant for the position of orderly, to inform him of his salary and his sleeping place and afterwards to pay little attention to him.

The hospital is largely at fault in the unfortunate occurrence described. In this instance, it was learned that the orderly had never received any instruction as to the necessity of sparing the feelings of visitors and others while transporting bodies to the morgue, nor had the elevator operator been informed that he must not carry passengers and bodies at the same time. In hospitals that are properly equipped, the presence of a service elevator makes such an occurrence impossible. Yet if any one had taken enough trouble to instruct this orderly, such an unfortunate occurrence could have been avoided.

Orderlies should be answerable to the nurses in charge of the departments in which they work. They should be selected as carefully as possible. A living wage should be paid. Both didactic and practical instruction in which the technique of handling patients and bodies is thoroughly discussed should be given them. When it is discovered that employees do not show evidence of desiring to perform their work efficiently, others should be secured to take their places. The hospital has no right to have working within its walls those who have not been taught their duties and the proper methods of carrying them out.

Disturbing but preventable instances of carelessness will continue to take place unless some care is given to this matter. In the commercial field, salesmen, elevator starters and others are carefully drilled in methods of meeting the public. The hospital, often hiding behind the humanitarian aspect of its work and usually professing to know better but announcing the impossibility of perfection because of a lack of funds, has been content to follow along beaten paths rather than to endeavor to compete with industry in efficiency methods. The institution that permits such occurrences to happen often will experience much difficulty in maintaining the loyalty of its clientele.

SHOULD AN ASSOCIATE HAVE ANY REDRESS IF HIS CHIEF ASKS HIM TO RESIGN?

It would be a fine thing indeed if it were never necessary to rule relative to such a question asked by the administrator of a specialty institution in the Middle West. In this particular instance, a visiting surgeon has for valid or other reasons lost confidence in his first assistant. A trivial personal matter gradually developed into an irreconcilable breach between these physicians. The aggrieved assistant sought the aid of his friends on the staff in securing justice and the surgeon, feeling more than ever that his assistant was disloyal, demanded his resignation. This the assistant refused to give and appealed to the executive committee of the staff for support. An unpleasant situation thus developed which was rapidly undermining the morale of the staff and which required firm and decisive action.

If a visiting surgeon or physician is to be held responsible for the proper care of patients under his charge, he should be given a free hand in the selection of his assistants. Moreover, when for any reason he desires to change from one assistant to another, he should be given the support of the board of trustees as well as of the administrative body of the staff. To be sure, even the visiting physician of unusual eminence is not always fair to or considerate of his subordinates. If improper or persecutory methods are adopted, instead of refusing him the right of choosing his assistants, perhaps the board of trustees should seek another visiting chief. But as long as the rank and prerogatives of a member of the major staff are possessed by a physician, there should be no interference with his choice of those who will assist him.

In this instance, the executive committee of the staff and the board of trustees as well could adopt no other policy than to support the chief in his request for the resignation of his assistant.

DO YOU OPERATE ON A BUDGET?

IF YOU DO, you know what it is to have unforeseen expenses come up and disrupt your plans — like, for instance, having an elevator go wrong because it hasn't been properly cared for. An elevator, like any other piece of fine precision machinery, cannot render continuous maximum service without regular skilled care.

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It must be remembered, however, that not only maintenance of elevators but the elevators themselves can either add to or detract from the convenience and comfort of the hospital. The research department of Otis has put an inestimable amount of effort in the perfection of elevators. Because of it, patients can now be transported from floor to floor without jolting. The modern hospital elevator accelerates rapidly but very smoothly. It comes to an almost imperceptible stop and always exactly level with the landing. Patients on stretchers hardly know they're being transported and visitors do not stumble as they enter or leave the cab. Because of these recent improvements in vertical transportation by Otis, modern elevators and elevator service are as much a part of the modern hospital as finely equipped operating rooms.

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NEWS OF THE MONTH

Catholic Hospital Leaders of Three States Meet in San Francisco

THE eighth annual conference of the California-Arizona-Nevada Hospital Association was held October 27 to 29 in the spacious and attractive auditorium of St. Mary's Hospital, San Francisco. Almost every Catholic hospital in these three states was represented at this conference. There were many present from a distance, including Rev. Maurice Griffin, S.J., Cleveland, vice-president and member of the board of directors, Catholic Hospital Association; Ray M. Kneiff, St. Louis, executive secretary, Catholic Hospital Association, and Dr. Malcolm T. MacEachern, Chicago, associate director, American College of Surgeons, who presided at all the sessions and conducted several round table conferences, assisted by G. Waite Curtis, San Francisco, and Dr. G. N. Drysdale, Sacramento, Calif., member of the staff of the Mater Misericordia Hospital. The conference was fortunate in having present Rev. R. F. Lucey, director of Catholic hospitals of the diocese of Los Angeles and San Diego. His contribution to the discussions was inspiring and instructive.

How Depression Is Affecting Hospitals

The conference opened with an interesting and enlightening discussion on ways and means of meeting the present economic condition in hospitals, led by G. Waite Curtis. A show of hands revealed that few, if any, were reducing expenses either through reduction of salaries or personnel. Of the two methods, however, the former was preferred by the majority present. It was pointed out during the discussion that the price of commodities generally has dropped about 20 per cent, and that this saving, with the general economies effected, would warrant a reduction in hospital charges to increase the bed occupancy and to compete with county hospitals taking pay patients. The chairman, Doctor MacEachern, pointed out that he believed this economic depression would result in more efficient business methods in hospitals in the future because it has demanded a careful inspection of business methods on the part

of all hospital executives. This should be of educational value to the administrator.

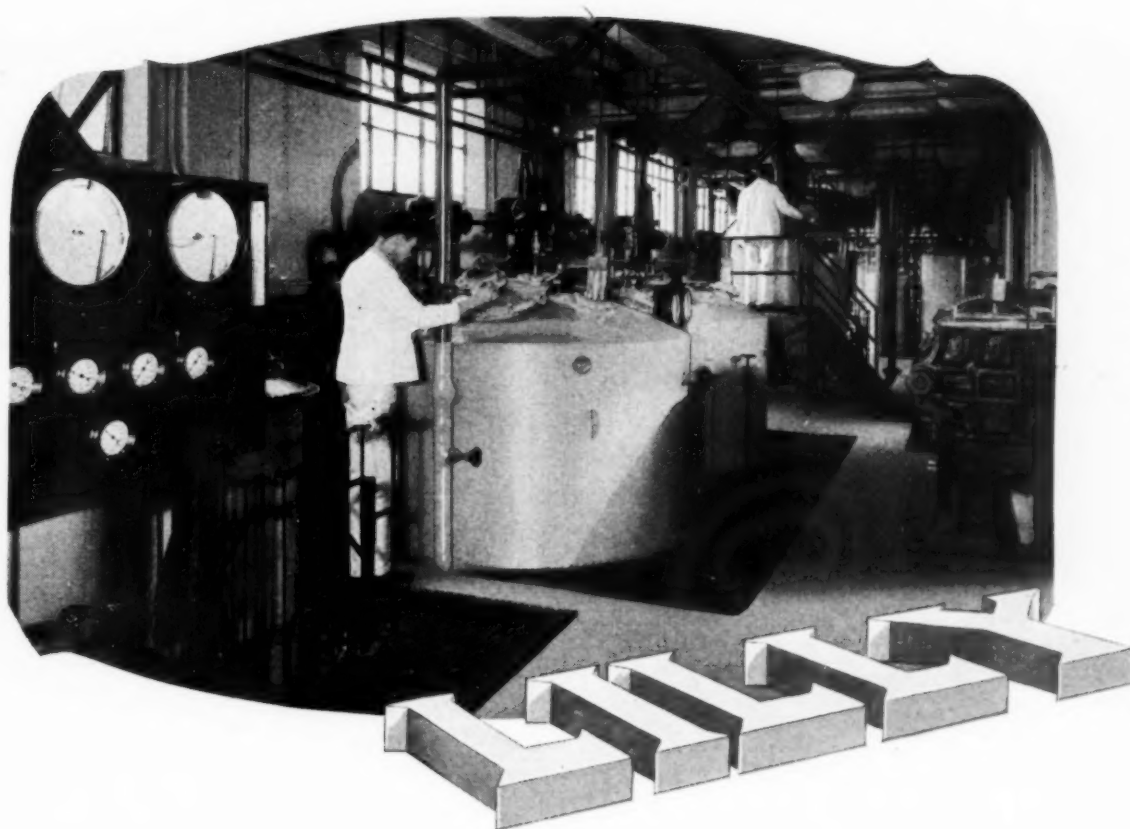
There was considerable discussion on all phases of nursing arising out of the papers presented at the nursing session. Anna C. Jamme, San Francisco, director of headquarters, California State Nurses' Association, gave a report on the grading committee and schools of nursing. Discussion focused on the oversupply of nurses and comparative costs of graduate and student nurse service. It was generally agreed that there were too many schools of nursing and too many nurses being graduated, and that it was less expensive to run a hospital with graduate nurse service than with student nurse service.

Hospital Legal Rights Are Discussed

An excellent paper on "Hospital Legal Problems and Responsibilities" was given by Frank Murphy, attorney, San Francisco, in which he emphasized clearly and definitely the fact that the hospital has many legal rights as well as legal responsibilities. His discussion was free from emphasis on technicalities, which usually annul the legal right, and frequently are greatly emphasized in discussions on this subject. The establishing of the right of the board of trustees or governing body to appoint the staff and to be responsible for the acts of its agents or employees has given hospitals important legal authority and legal responsibility. Both these phases were discussed at length.

Excellent papers were presented by the Sisters on such topics as nursing service and administration, ward and departmental supervision, diet therapy and central supply room. In addition, many other important topics were discussed.

The papers throughout were well planned and the subject matter well presented. There was an interesting commercial and educational exhibit. The hospitality of the Sisters of St. Mary's Hospital could not be excelled. Everyone enjoyed the privilege of seeing this splendid institution.



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PROGRESS THROUGH RESEARCH

NEWS OF THE MONTH (Cont'd)

Record Librarians of Chicago Meet on November 12

A meeting of the Association of Record Librarians of Chicago and Cook County, Illinois, was held at the Municipal Tuberculosis Sanitarium, Chicago, November 12.

The program consisted of the following discussions: "Sanitarium Management," Dr. Peter S. Winner, acting general superintendent, Municipal Tuberculosis Sanitarium; "The Tuberculosis Problem in Chicago," Dr. Allan J. Hruby, secretary of the sanitarium; "The Use of Clinical Records," Dr. Malcolm T. MacEachern, associate director, American College of Surgeons.

A report of the Association of Record Librarians of North America was given at the meeting.

\$2,000,000 Women's Pavilion Planned for Harlem Hospital

A \$2,000,000 women's pavilion and nurses' home is shortly to be built at Harlem Hospital, New York City. The improvements to be made in the hospital will materially lower Harlem's maternal and infant mortality "which is the highest in the world," according to Dr. Louis T. Wright, secretary of the hospital's medical board.

At the present time the hospital has a bed capacity of 325 but it has had a daily average of more than 400 patients for over a year. The new building will accommodate 250 patients and more than 250 nurses. It will harmonize architecturally with the rest of the hospital plant.

Mayor Walker, who officiated at the recent ground breaking ceremonies, characterized the institution as a "monument to racial tolerance" and praised the achievements of the colored physicians and nurses on the hospital staff. More than half of the physicians at the hospital are colored.

Cornerstone of \$500,000 Hospital for Negroes Is Laid

Approximately 6,000 persons, including members of Negro churches, fraternal orders, affiliated religious groups and musical organizations, attended the formal ceremonies that were held

recently in connection with the laying of the cornerstone of the new \$500,000 Flint-Goodridge Hospital, New Orleans.

Officials of Dillard University, of which the hospital is the first unit to be completed, representatives of the Rosenwald Foundation, philanthropic organizations aiding in the work and members of out-of-town educational and medical institutions interested in work for Negroes were speakers.

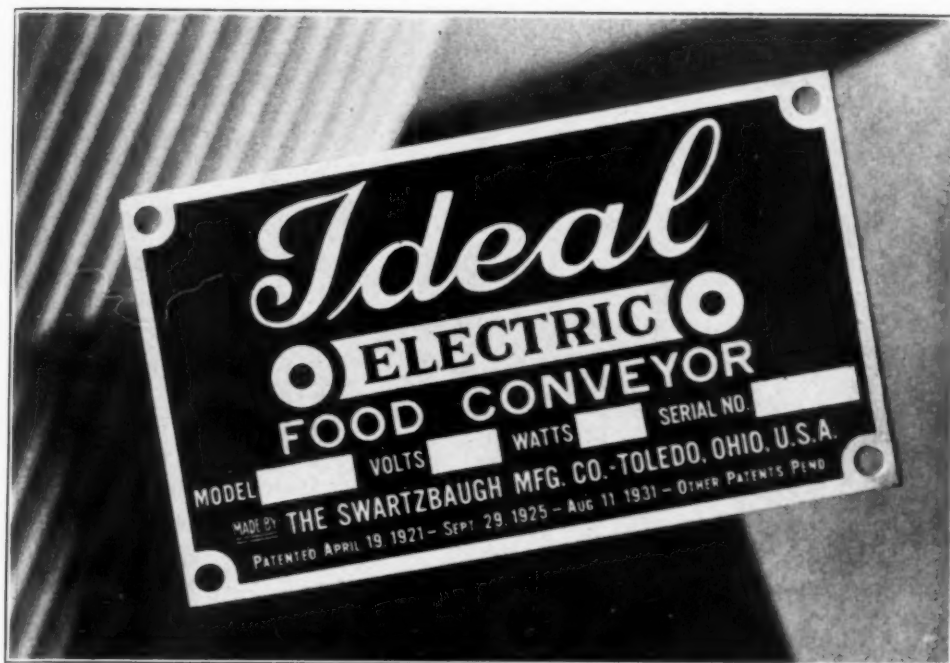
Fraudulent Subscription Solicitors

Information has reached the publishers that subscription solicitors are representing themselves as authorized to take subscriptions for THE MODERN HOSPITAL, and are using the name of this magazine to gain audience with hospital executives. THE MODERN HOSPITAL, in common with better class professional magazines, does not employ subscription solicitors, and anyone so representing himself is an impostor. Any "special offers" that are made are likewise unauthorized, as THE MODERN HOSPITAL is one price to everyone with no so-called inducements, premiums or bargain prices.

In order that hospitals may be protected against dishonest solicitors it is suggested that superintendents deal directly with the publishers of magazines or through a recognized news agency, and thus eliminate the risk of losing the subscription payment or of being "high pressured" into buying something that is not wanted.

Publicity Secretary of A. N. A. Resigns —Illness Is Cause

Virginia McCormick has resigned as publicity secretary of the American Nurses' Association. Miss McCormick, who has been with the association for three and a half years, goes under doctor's orders for a needed rest in a Southern climate. Her successor is Eleonore von Eltz, until recently engaged in publicity and extension work for the City Housing Corporation in its town building project at Radburn, N. J.



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2. Insist on references as to equipment he has previously designed, engineered and produced.
3. Scrutinize specifications diligently, comparing them with known standards of quality, and then make sure you get what you pay for.
4. Insist on a five year unqualified guarantee on electrical elements.
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NEWS OF THE MONTH (Cont'd)

Modernistic Scheme Is Effective in New Passavant Pavilion

Passavant Memorial Hospital, Chicago, acquired something new and very lovely when the Gertrude Keeley Terrace was formally opened, November 6. It is the gift of James Keeley, a member of the board of trustees and is a tribute to the memory of his wife.

This memorial pavilion, an architectural novelty, is a large glass and aluminum structure and is intended for summer and winter use by convalescent patients. It is on the ninth floor of the hospital and extends across one end of the building, thus commanding a view of the wide stretches of Lake Michigan and of the lawns and the towers of Northwestern University.

The decorative scheme is entirely in black and silver and gray and this combined with the clever lighting effects, particularly the blue spotlights on the unenclosed ends of the terrace, at night

achieves an effect of soft and restful moonlight.

On entering the room the visitor is faced by the south wall which is entirely covered by eleven unique mirror panels. On these, ultramodern decorative motifs have been etched by a special sand-blasting process, the design being accented by color applied on the underside of the plate glass. In the center of the wall is a little fountain that plays continually. It is enclosed in a triangular green glass case and is illumined by a concealed light hidden under the fountain. Across the wall at the foot of the series of panels are flower boxes filled with many varieties of dwarf cactus.

Outside the glass room, on either side, are two small roof gardens, surrounded by a thick hedge of evergreen shrubs. Here recuperating patients may lounge when the sun shines, withdrawing when the chill breezes blow to their glass enclosed shelter.

The decorations were planned by Elizabeth Hoffman, and Philip Maher, Chicago, was the architect.



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NEWS OF THE MONTH (Cont'd)

Dietitians Spend Four Valuable Days in Cincinnati

FOUR interesting days were spent in Cincinnati by the dietitians who attended the American Dietetic Association, October 19 to 22. The registration was large and the attending delegates expressed an appreciation of the inspirational value of the meeting.

Breakfast, luncheon and dinner meetings were held practically every day with section chairmen presiding, and many reports were given by members of the association. Each section presented a vast amount of valuable information showing notable progress during the year.

Doctor Bachmeyer Gives Address of Welcome

Speakers at the general sessions included Dr. A. C. Bachmeyer, superintendent, Cincinnati General Hospital, who gave an address of welcome and an inspirational talk on "The Dietitian as an Administrative Officer in the Institution," and Dr. Julius Hess, Michael Reese Hospital, Chicago, who talked on "Infant Feeding." Mabel Little, La Salle Koch Tea Room, Toledo, Ohio, spoke on "Styling Food," Martha Koehne, University of Michigan, Ann Arbor, on "Studies of the Relation of Diet to Dental Caries," Doctor Newburg, University of Michigan, on "Insensible Weight Loss," Dr. F. H. Lashmet, department of internal medicine, University of Michigan, Ann Arbor, on the "Control of Edema" and Dr. James P. O'Hare, associate in medicine, Peter Bent Brigham Hospital, Boston, on "Present Day Dietetic Therapy in Nephritis and Allied Conditions."

All brought to the members the most recent developments in each field. The usual procedure was presented by Doctor O'Hare and a radically new treatment of edema was described by Doctor Lashmet. In Miss Little's paper and in the one presented by Arnold Shircliffe, Belden Stratford Hotel, Chicago, stress was laid on the preparation and service of foods. Miss Little gave many suggestions for new and attractive dishes and Mr. Shircliffe outlined the largest number of servings of vegetables, meat and sauces that might be cooked at one time, if one is to obtain the "finesse" in the art of cookery which is so desirable in the serving of food.

In the social service section interesting reports were given on teaching methods in out-patient de-

partments, on bibliographies of articles giving the background for dietaries for the foreign born, on the teaching of adults and on the influence of the White House Conference on child health, with a report as to what material is and will be available to dietitians who desire information on these various subjects.

Probably the high light of the whole convention was in the address presented by Judge Florence E. Allen, Supreme Court of Ohio, at the banquet. Judge Allen's talk was not only delightful and inspirational, but she placed a definite responsibility on the dietitian in the problems confronting our country at the present time in feeding those who have become victims of an unfortunate economic situation. The teas and luncheons given by the various local organizations added greatly to the pleasure of the guests and the work of the local arrangement committees cannot be too highly praised. The convention was outstanding for its excellent meetings, for its inspirational value and for its opportunity for the friendly exchange of ideas.

Martha Koehne, school of dentistry, University of Michigan, is the president of the association. Kate Daum, University of Iowa Hospitals, is the president-elect. Other officers chosen were: first vice-president, Katherine Mitchell Thoma, dietitian, Michael Reese Hospital, Chicago; second vice-president, Annie L. Laird, professor of household science, University of Toronto; secretary, Phyllis Dawson Rowe, chief dietitian, Johns Hopkins Hospital, Baltimore; treasurer, Nelda Ross, director, department of nutrition, Presbyterian Hospital, New York City.

Oregon Dietitians View Up-to-Date Hotel and Hospital Equipment

The Oregon Dietetic Association held its regular monthly meeting in the auditorium of the Dohrman Hotel Supply Company, Portland, October 14. Following a brief business meeting the members listened to a discussion on the porcelain and silver features of tray service. The most modern in hospital kitchen equipment was on display for the benefit of those attending.

Elizabeth Baldwin is president of the Oregon association and Dorothy James Keane is secretary-treasurer.

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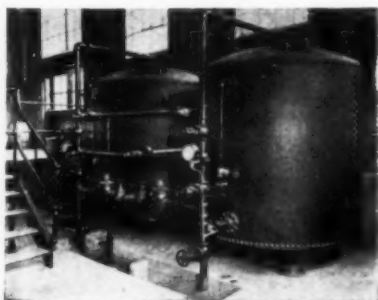
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Saving on laundry sodas	75
Saving on linen renewals	1,500
Cost of special soaps, chemicals and scouring powders	50
Cost of renewing sterilizing coils	50
TOTAL	\$4,575



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NEWS OF THE MONTH (Cont'd)

Colorado Will Join Midwest Association

The seventh annual meeting of the Colorado Hospital Association was held in Colorado Springs, November 10 and 11. This proved to be the most interesting and best attended meeting the association has ever held.

Following the policy adopted three years ago, there was no exhibit. The program was divided into four sections: an administrative section, a nursing section, a round table section and a dietetic section.

The guest speakers at the meeting were: Dr. Bert W. Caldwell, executive secretary, American



Frank J. Walter, superintendent, St. Luke's Hospital, Denver, was elected president.

Hospital Association, and E. Muriel Anscombe, superintendent, Jewish Hospital, St. Louis, who is president of the Midwest Hospital Association.

The business meeting was held on the second day, following the program of the dietetic section. The following officers were elected: president,

Frank J. Walter, superintendent, St. Luke's Hospital, Denver; first vice-president, Guy M. Hanner, superintendent, Beth-El Hospital, Colorado Springs; second vice-president, Sister Sebastian, Mercy Hospital, Denver; treasurer, R. J. Brown, Boulder-Colorado Sanatorium, Boulder; trustee, Dr. Maurice H. Rees, dean, University of Colorado School of Medicine and Hospitals, Denver.

The association passed a resolution condemning the further building of veterans' hospitals so long as the veterans can be accommodated in the beds available in civilian hospitals, at a cost to the Government not to exceed the present per patient day cost in Government hospitals.

The association authorized the sending of a delegate to the proposed meeting of officers of the state associations to be held under the auspices of the American Hospital Association sometime in the near future in Chicago.

The Colorado Hospital Association voted to affiliate with the Midwest hospital group.

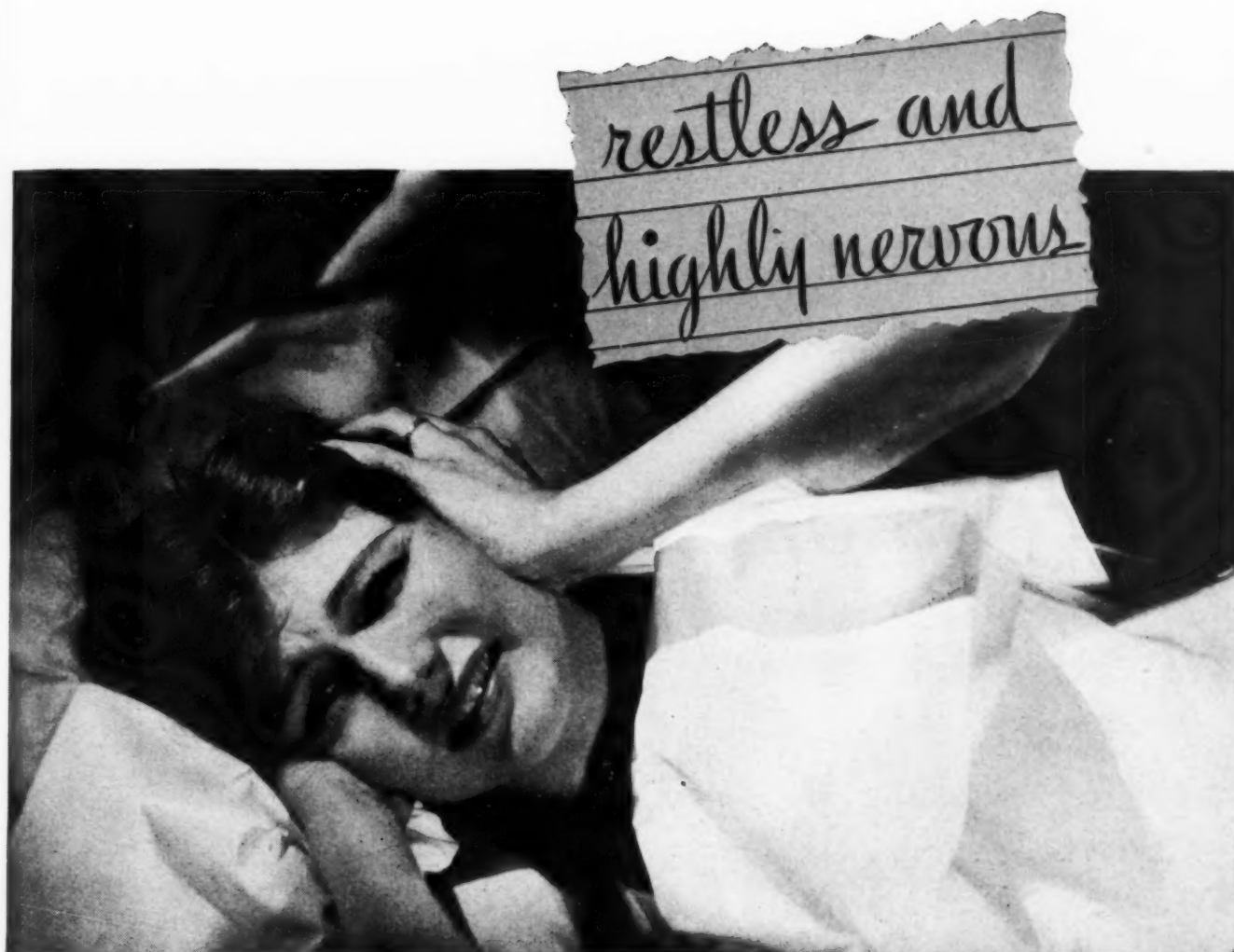
The association also voted to continue using its allotted space in *Colorado Medicine*, the official publication of the Colorado Medical Society.

It might be of interest to note that the legislative committee proposed plans for the future enactment of the following legislative measures for the protection of hospitals: a law placing the hospitals under the same protection in regard to the payment of accounts which hotels now receive; more adequate protection for the hospitals in cases handled under the compensation and insurance laws.

Connecticut Hospital Historians Meet in Torrington

The Connecticut Hospital Historians' Association met at the Charlotte Hungerford Hospital, Torrington, November 7. Thirty-one members were present. Enna C. Black, the president, presided.

Interesting reports on the recent conference of the Association of Record Librarians of North America were given by Louise A. Plate, New Haven General Hospital, Grace E. Gillespie, Stamford Hospital, and Ruth Gandrup, Norwalk General Hospital. Dr. Allan Craig, director, Charlotte Hungerford Hospital, welcomed the association and spoke a few words of greeting.



and Hospital Noise is largely to blame

DR. LLEWELLYN F. BARKER, Professor of Medicine at Johns Hopkins University, aptly sums up the indictment against noise in hospitals in these words: "We can put out the light, we can close our eyes, but there is no satisfactory way of closing our ears to the extreme stimulation of noise which acts on the brain and prevents sleep . . . almost all sick persons are in a state of pathological fatigue and loud, disagreeable noise increases this fatigue to the danger point."

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have perfected materials which absorb noise as a sponge absorbs water. Among these is Sanacoustic Tile, especially suited for hospital use. Inorganic and strictly sanitary, easily cleaned, attractive in appearance and of high light-reflecting value; it is non-combustible—the *only* acoustical material approved by the Underwriters' Laboratories.

Sanacoustic Tile will absorb up to 80% of hospital noise—the highest coefficient of sound absorption of any material used in

hospitals today.* Let Johns-Manville quiet the noise in your wards and corridors—in your kitchens and dining rooms—in utility rooms, nurseries, waiting and examining rooms. Ask our nearest office to arrange for a visit by a J-M Sound Control Expert or write Johns-Manville, 292 Madison Ave., New York City.



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* "Shushing the Old Building" . . . Hospital Topics, February, 1931.

NEWS OF THE MONTH (Cont'd)

Dates for Meeting of Western Association Are Announced

The next annual meeting of the Western Hospital Association is announced for June 14, 15 and 16 at Salt Lake City, Utah.

Heading the committee on general arrangements is Frank Pingree, superintendent, Dr. W. H. Groves Latter-day Saints Hospital, Salt Lake City. W. W. Rawson, superintendent, Thomas D. Dee Memorial Hospital, Ogden, Utah, is chairman of the committee on programs.

The Western Hospital Association includes hospitals in Arizona, Montana, Colorado, Nevada, Utah, California, New Mexico, Washington, Idaho, Oregon, Wyoming and British Columbia.

New Physical Therapy Clinic at Temple University Hospital

A clinic in which will be used the latest physical equipment for the treatment of disease has recently been opened at Temple University Hospital, Philadelphia. The hospital has set aside an entire floor where patients may be treated by means of heat, air, light, water and mechanics, and equipment for these treatments has been installed.

Chicagoan Gives Preventorium to Arbonne in Pyrenees Region

Benjamin Rosenthal, Chicago, has presented a preventorium to Arbonne, in the Pyrenees region of France. It was opened recently with ceremonies presided over by Léon Bérard, minister of justice.

Grasslands Is Host to Class in Institution Management

On November 7 about forty members of the class in institution management of Teachers College, Columbia University, journeyed by bus from the university to Grasslands Hospital, Valhalla, N. Y. Rhoda A. Tyler, dietitian of the hospital, with her assistants and students, were hostesses to the group. Five of the buildings of the hospital were visited and especial attention was given to food service facilities in the new Children's Build-

ing, the Tuberculosis Hospital and the Psychiatric Institute. The group was headed by Mary DeGarmo Bryan of the Teachers College faculty.

Methodist Association Sets Date for Next Meeting

The Methodist Hospital Association will hold its annual meeting in Chicago on February 10 and 11 at the Congress Hotel. This meeting is always attended by some eighty to a hundred hospital superintendents and others from Methodist homes.

Coming Meetings

Iowa Hospital Association.

President, Robert E. Neff, University of Iowa Hospitals, Iowa City.

Secretary, Clinton F. Smith, Allen Memorial Hospital, Waterloo.

Next meeting, Sioux City, March 9-10.

National Methodist Hospitals, Homes and Deaconess Work Association.

President, Dr. John G. Benson, Methodist Episcopal Hospital, Indianapolis.

Secretary, Guy M. Hanner, Beth-El General Hospital, Colorado Springs, Colo.

Next meeting, Chicago, February 10-12.

North Carolina Hospital Association.

President, Dr. Harold Glascock, Mary Elizabeth Hospital, Raleigh.

Secretary, Edwin G. Farmer, Carolina General Hospital, Wilson.

Next meeting, Richmond, Va., May 17-19.

Hospital Association of New York State.

President, Carl P. Wright, Syracuse General Hospital, Syracuse.

Secretary, Julian Funt, Beth Israel Hospital, New York City.

Next meeting, May 5-7, New York City.

Hospital Association of Pennsylvania.

President, M. H. Eichenlaub, Western Pennsylvania Hospital, Pittsburgh.

Secretary, Howard E. Bishop, Robert Packer Hospital, Sayre.

Next meeting, Pittsburgh, March 15-17.

South Carolina Hospital Association.

President, F. O. Bates, Roper Hospital, Charleston.

Secretary, H. H. McGill, Columbia Hospital of Richland County, Columbia.

Next meeting, Richmond, Va., May 17-19.

Virginia Hospital Association.

President, Dr. Knowlton T. Redfield, Jefferson Hospital, Roanoke.

Secretary, M. H. Coleman, Jr., Johnston-Willis Hospital, Richmond.

Next meeting, Richmond, May 17-19.

Western Hospital Association.

President, Dr. B. W. Black, Highland Hospital, Oakland, Calif.

Secretary, Mrs. Lola M. Armstrong, Los Angeles.

Next meeting, Salt Lake City, Utah, June 14-16.

Fever Therapy with Diathermy

Various chronic diseases now treated by this method

IT is little more than two years since the first published articles^{1,2,3} on the use of diathermy in the production of therapeutic fever aroused interest in the possibilities of this new method.

The encouraging clinical results reported by these early workers in the treatment of paresis, and their predictions that diathermy would ultimately prove quite as valuable in the treatment of other chronic diseases, have led to a considerable amount of investigation and research which elicit worldwide interest.

Subsequent articles by Feinberg and Osborne⁴, and by Schmidt and Weiss⁵, reporting favorable clinical results with diathermy used to produce fever in the treatment of allergic disease and multiple sclerosis, respectively, have served to further intensify the interest in this method of fever therapy.

In your consideration of apparatus for this form of therapy, allow us to submit to you reprints of several articles on the subject, in which the authors state the essential requirements of equipment suitable for this work.

The Victor Super-Power Diathermy Apparatus was specially designed for this particular purpose. From the standpoint of energy output, it will give as much current as any patient can tolerate through the chest and abdomen, with the largest size electrodes used thus far in this work. The maximum degree of fever is therefore reached in the shortest possible time.

The design of the Super-Power permits the selection of both frequency and voltage, so that any desired quality of current is quickly available. The refinement of control and simplicity of operation insure accurate dosage and exact duplication of any current value where it is desired.

Aside from its use in producing therapeutic fever, the Victor Super-Power serves every present-day need in medical diathermy, with a reserve power to meet possibly increased requirements of new technics as they develop.

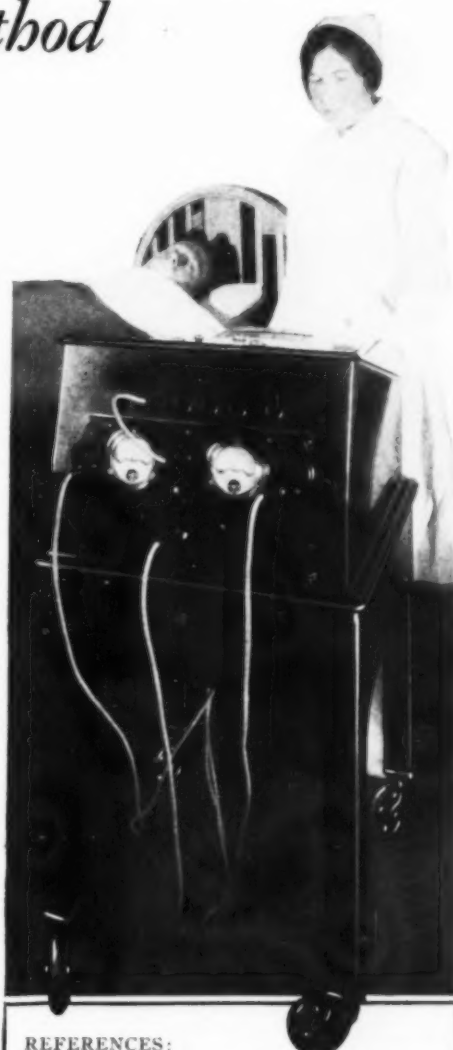
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REFERENCES:

1. Artificial Fever Produced by High Frequency Currents—Preliminary Report. By Clarence A. Neymann, M.D., and S. L. Osborne, B. P. E., Ill. Med. J., Sept., 1929.
2. Therapeutic Fever Produced by Diathermy: its Application in the Treatment of Paresis. By J. Cash King, M.D., and Edwin W. Cocke, M.D., So. Med. J., March, 1930.
3. The Treatment of Dementia Paralytica with Hyperpyrexia Produced by Diathermy. By Clarence A. Neymann, M.D., and S. L. Osborne, B. P. E., J. A. M. A., Jan. 3, 1931.
4. A New Method of Nonspecific Treatment of Allergic Disease—Preliminary Report. By S. M. Feinberg, M.D., M. L. Afremow, M.D., and S. L. Osborne, B. P. E. Jour. Allergy, II:4:291, May, 1931.
5. Fever Produced by Diathermy: Its Value in Multiple Sclerosis and Other Chronic Diseases. By Wm. H. Schmidt, M.D., and Benj. P. Weiss, M.D. Physical Therapeutics, XLIX:8, Sept., 1931.

NEWS OF THE MONTH (Cont'd)

Two Women's Hospitals in Philadelphia Merge

The Woman's Hospital of Philadelphia and the West Philadelphia Hospital for Women have recently been amalgamated, and the amalgamation sealed with the laying of the cornerstone for the new building of the Woman's Hospital, Preston and Parrish Streets, Philadelphia.

The new building will be seven stories high, of brick and limestone, with provision for 160 beds. It will cost \$530,000. It will be equipped for medical, surgical and pediatric work. Construction, which began May 1, is expected to be completed February 1.

First County and State Hospital Opened in New York

The first hospital to be built under the joint auspices of county and state, under a recently enacted law in New York State, is the new Lewis County Hospital that was opened recently at Lowville, N. Y. It was built at a cost of \$220,000.

The hospital occupies a commanding site on an eminence that looks across a valley that extends thirty miles or more to the mountains beyond. The building is approached by winding drives with an entrance from the northern and southern extremities of the property. Concrete walks for the pedestrians follow the winding road from the highway to the portico of the hospital.

The architecture of the building is colonial, with four white columns supporting the portico. The interior of the hospital is modern in every detail.

Lucy J. Johnston is the superintendent.

Varied Programs Attract Chicago Dietitians

Members of the Chicago Dietetic Association met on November 18 and heard an excellent talk by Dr. Joseph Greengard, who is on the teaching staff of the University of Illinois and on the medical staffs of Cook County and Michael Reese Hospitals and St. Vincent's Orphanage, Chicago.

In his discussion of "Nutritional Anemia in Infancy and Its Treatment With Liver Extract

and Iron," Doctor Greengard said: "There seems to be good evidence that nutritional anemias in infancy result from a failure of storage at birth of iron and copper as well as of some food accessory substance concerned with their utilization, combined with a dietary over the first half year of life definitely deficient in these factors. In many instances, this anemia may be corrected by the administration of adequate doses of inorganic iron. Liver extract seems to exert an even more favorable influence on these anemias and results in a definite increase in hemoglobin and red cells as long as the iron store is adequate for their formation. When the iron store is exhausted, the addition of adequate amounts of inorganic iron to the dietary will result in further gain in hemoglobin and red cells. In addition, liver extract seems to exert a definitely beneficial effect on general nutrition."

The program of the October meeting was comprised of reports of the American Dietetic Association meeting in Cincinnati. The following reports were presented: social, Genevieve Gormican, Michael Reese Hospital; administrative, Elsie Jo Nelson, Mercy Hospital, Gary, Ind.; dietotherapy, Beulah Hunzicker, Presbyterian Hospital; community health, Clara Kurtz, Infant Welfare Society.

At the September meeting Dr. F. J. Fogelson, instructor in surgery, department of experimental surgery, Northwestern University, spoke on "The Present Status of Mucin in the Treatment of Peptic Ulcer."

Jeanes Hospital Opens Enlarged Radium Service

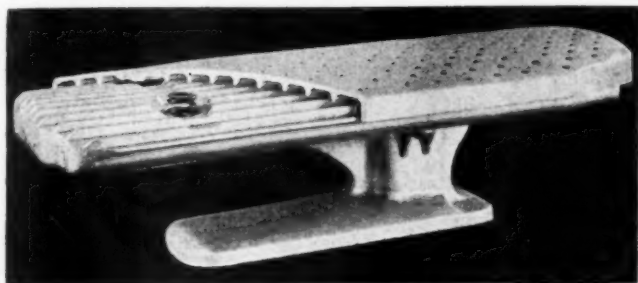
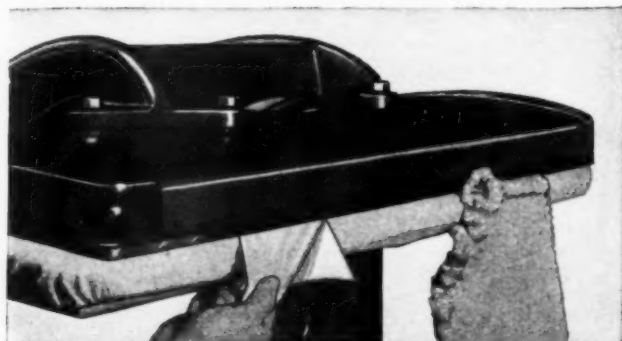
Formal announcement has just been made of the opening of the enlarged radium service of Jeanes Cancer Hospital, Fox Chase, Philadelphia, by J. Wilmer Lundy, president, board of trustees.

During the past month, half of the hospital's additional two-gram radium supply, recently purchased at a cost of \$120,000, has been installed in the newly constructed emanation plant. Delivery of the remaining gram, which is expected to come from Belgium within the next few weeks, will bring the hospital's supply up to 2,100 milligrams, one of the largest in the Philadelphia area.

★

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PRESS CLOSED. The upper illustration shows a photograph of the Unipress closed on two pieces of cloth. The large piece consists of three thicknesses of $\frac{5}{8}$ -inch padding, the small piece of a single cloth of handkerchief size. Note the pressure on the thin cloth, so much in fact that it is impossible to pull it out. A difficult test, but Unipress can pass it easily because of its unique construction, which consists of a special revolving wedge, coupled with its flywheel action, giving at all times the same fine finish to all characters and thicknesses of cloth — absolutely without adjustment. The lower illustration shows the Unipress lower buck and bellows pad construction — radiating fins for quick heat and springs for equalized pressure on all types of garments. Note the perforations which keep padding hot and dry at all times.

THE RESULT. The result is that Unipress brings to every hospital laundry in which it is installed uniform high quality work under all pressing conditions—not some days, but every day—and makes possible the famous Unipress “hand ironed” appearance. To the laundry interested in better work at lower labor cost, Unipress is proving a life-saver, as any laundry girl, after a half hour's experience, can turn out work as fine as that done by the most expert hand retouchers. Write for proof of these statements.

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As in the history of all great movements, the progress of Nursing was sometimes expressed by groups rather than by individuals.

One of these groups was the Beguines, founded in Belgium toward the close of the twelfth century to give women an opportunity to live pious lives, separate from a man's world, without taking strict conventual vows. In their little communities they built hospitals which were models of order and cleanliness.

The idea spread rapidly. In the thirteenth and fourteenth centuries nearly every town in Europe had its Beguinage where days were spent in quiet living and in serving the sick and needy. Some of these communities still exist, maintaining, unchanged, the simple, dignified traditions of the order.

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PERSONALS



DUFF GREEN MAYNARD, superintendent, Presbyterian Hospital, New York City, died on November 11. He had been in ill health since last February. MR. MAYNARD had been connected with the hospital for almost five years.

DR. R. C. WOODARD has been appointed superintendent of the Jackson Memorial Hospital, Miami, Fla., succeeding DR. ALEXANDER J. MCRAE.

DR. HERBERT G. BURDEN, medical superintendent, Walla Walla Sanatorium, College Place, Wash., has resigned to enter private practice.

LUCY ANN MARSHALL has resigned as superintendent, Seaside Hospital, Long Beach, Calif.

SISTER M. EMERENTIA, who has been for the past six years in charge of St. Mary's Hospital, Gallup, N. M., is the new superintendent, St. Francis Hospital, Colorado Springs, Colo.

DR. WILLIAM D. CUTTER, formerly dean, University of Southern California Medical School, Los Angeles, has been elected secretary, Council on Medical Education and Hospitals, to succeed DR. NATHAN PORTER COLWELL.

SISTER M. PASCALINE has been appointed superintendent, St. Joseph's Hospital, Kansas City, Mo., succeeding SISTER M. LAURENTIA who died on October 20.

DR. J. H. POUND has been named as superintendent, Florida State Hospital, Chattahoochee, Fla. For the last four years DOCTOR POUND was the assistant physician at the hospital.

GEORGE J. WERNER, for seven years commissioner of public welfare, Westchester County, New York, died on October 23. Among the institutions that came under MR. WERNER's supervision was Grasslands Hospital, Valhalla, N. Y., in whose growth and development he was keenly interested.

V. W. OLNEY, formerly superintendent, French Hospital, San Francisco, has been appointed superintendent, St. Francis Hospital, San Francisco. VINCENT LABRUCHERIE succeeds MR. OLNEY at French Hospital.

DR. J. H. LINSON, surgeon, U. S. Public Health Service, is the new superintendent, United States Marine Hospital, Detroit, succeeding DR. J. S. BOGGESS.

LORA E. McDONALD has succeeded T. J. MCGINTY as superintendent of the Oklahoma Baptist Hospital, Muskogee, Okla.

ADA KOEBKE, Kahler Hospitals School of Nursing, has been appointed director of nursing, Ravenswood Hospital, Chicago, succeeding NAN H. EWING.

ADELINE M. HUGHES, superintendent, Passavant Memorial Hospital, Jacksonville, Ill., for the past three years, assumes the superintendency of the Jewish Hospital, Louisville, Ky., on December 1.

AIMEE LINSENMYER of the Braddock General Hospital, Braddock, Pa., is the newly appointed superintendent, Latrobe Hospital, Latrobe, Pa., succeeding ROXANNA GRAY.

SISTER REDEMPTORA, formerly at St. Mary's Hospital, Watertown, Wis., has been appointed superintendent, St. Therese's Hospital, Waukegan, Ill.

L. STRENG, for the past three years surgical supervisor, Lutheran Hospital, Beatrice, Neb., has recently been appointed superintendent of Good Samaritan Hospital, Aberdeen, S. D.

DR. A. E. DOUGLAS, head of the Douglas Sanitarium, Nashville, Tenn., and previous to that superintendent, Central State Hospital for many years, died recently.

DR. JOHN T. BURRUS has been named head of the professional staff of the new Randolph Hospital, Asheboro, N. C.

ESTHER ISKER, Grand Rapids, Mich., is the new superintendent, Monmouth Hospital, Monmouth, Ill., succeeding RUTH JOHNSON, resigned.

New Clinical Building to Be Added to Veterans' Hospital

The contract for the construction of a clinical building as an addition to the present hospital facilities of the Veterans' Administration at Augusta, Ga., has been awarded, the administration announced October 1. The amount involved is \$297,765, the administration said.

Etiologic Aspects of Aluminum

Résumés of Recent Researches

A pernicious and far-reaching campaign of propaganda on the cause of certain maladies including cancer has been in progress for some time.

This campaign is pernicious, because it is based on the layman's fear of a very serious disease, of which the exact cause and specific remedy are not known.

It is far-reaching, because it erroneously ascribes as a cause, the use of aluminum cooking utensils, which are employed in more than 75% of American Homes.

The propaganda is supported by no demonstrable facts. It is evidently all based on suggestion and on appeal to fear of the unknown.

It is a challenge to the conscientious physician who bases his practice on scientific fact and whose purpose is to safeguard health.

It likewise presents an opportunity to persons connected with the medical profession to allay the fear of patients when that fear is expressed.

To support such work, this page will, for a time, be devoted to quotations from the published works of recognized medical authorities and from the reports of four years study of the effects of aluminum on food as conducted by scientists at Mellon Institute of Industrial Research.

NUMBER ONE
OF A SERIES

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NURSING AND THE HOSPITAL

Conducted by M. HELENA McMILLAN, R.N.
Director, School of Nursing, Presbyterian Hospital, Chicago

The Future of the Nurse Is the Responsibility of To-Day

By C.-E. A. WINSLOW, DR.P.H.
Professor of Public Health, Yale University

THE development of nurses' training in this country dates back to the late seventies. It began primarily as a result of the recognition by the persons connected with various hospitals of the need for trained women to do the nursing in those hospitals. The idea seemed to be so fruitful that the movement spread rapidly and to-day we have between 2,000 and 3,000 so-called nursing schools in operation.

The system of nursing education as it has grown up has two distinct assets. First, it has grown up in direct and immediate contact with a felt need, and, second, it has grown up with a technique, an educational technique, that is closely bound up with the actual service that the students are expected to perform.

The last objective is one of the things that we are trying to approximate in other fields of education. In the particular field that I represent—medical education—we have approximated it, and this is one of the reasons why medical education is perhaps more vital and effective than any other kind of professional education in the world to-day, because it is intimately connected with the hospital, with the clinic, with the patient.

Rockefeller Report Still Live Material

Nursing education has, then, had two advantages, and yet when one examines its history, its development and its present status, one realizes that these two advantages are overbalanced by many serious drawbacks. This has been shown by the studies carried out during recent years. It was also shown by the report of the Rockefeller Committee on Nursing and Nursing Education published in 1923. It is interesting to notice how that report is being rediscovered. It was quite

forgotten five years ago, but now I find that the Rockefeller Foundation is receiving many demands for the book and that people are turning back and reading it and finding that there is still something alive in it. The same thing has been shown during the past five years by the work of the Committee on the Grading of Nursing Schools.

An Anomalous Situation

It has been my privilege to serve as a member of this committee and of its executive committee, and it is some of the trends revealed by its work that I shall discuss. In the first place, all of these studies, particularly that of the Grading Committee, have shown that while the development of nursing schools did grow out of a felt need, it has become in recent years completely divorced from the need for nurses of the community as a whole, and the reason is that the felt need has been usually the need of a particular hospital only. Furthermore, a strange thing happened. The hospitals that at first planned to train nurses to serve them found that they could get enough work out of the nurses while they were being trained to fill the need, and therefore the hospitals did not need the nurses after they were trained. As a result, this unique situation arose—a practice originally and primarily educational in nature came to be a method of performing the function in hand by the work of the pupils themselves. Hospitals had need for few of their pupils after they completed their training, but more and more hospitals continued to turn out more and more nurses in order to get their work done.

This represents a complete divorcement not only between education and community needs but between the interests of the institution doing the

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training and the needs of the general community. The results have been just what one might anticipate—the flooding of the market with an immense number of graduate nurses out of all proportion to the possible power of the community to absorb these nurses and put them to work. Any good educational institution studies its markets and it restricts its output so as to meet community demands, but here such checking and balancing were wholly lacking. Those responsible for nursing education were under the strongest possible temptation, or thought they were, to recruit and use during training as many students as possible, with the result that our training schools are probably turning out about four times as many nurses as can be absorbed. About four times as many nurses graduate each year as pass out of the profession by old age and retirement, so that long before the present depression the conditions of unemployment among graduate nurses were of the gravest kind.

That then is our first indictment against the general system of nursing education—that it is operating with no reference to the needs of the community and is turning out vastly more nurses than the community can absorb, and year by year is continuing to aggravate the conditions of unemployment within the profession itself.

Too Much of the Wrong Kind of Product

There is a second objection that is even more serious. These educational mills are turning out too much product and they are also turning out the wrong kind of product.

In the present situation in spite of the tremendous need for work on the part of the average graduate nurse, there are not nearly enough nurses for positions of authority and responsibility, so that hand in hand with the oversupply of the average type of nurse is an undersupply of nurses competent to do administrative, teaching and public health work. There is no unemployment among well equipped nurses. All nursing organizations this year are finding difficulty in retaining the nurses they want and in getting others to fill vacancies. This educational system has not only failed through turning out too many nurses of a kind that the community cannot absorb, but it has also failed through turning out not enough nurses of the kind that the community needs.

I should like to illustrate the shortcomings of the system by citing certain figures from the work of the Grading Committee.

First of all, one-fourth of all the training schools in the country have twenty-two students or less and one-fourth of the schools are connected with hospitals having less than forty patients. These schools are too small and have too

small a body of clinical material to do their work effectively.

Another study deals with the distribution of the schools with respect to whether or not they have paid members on their instructing staffs. Forty-two per cent of the schools have no regular paid instructors, 42 per cent have one paid instructor, and 16 per cent have two paid instructors. These "educational" institutions function largely without the assistance of any educators except for such accidental kindly service as busy doctors and nurses may find time to give.

Of the instructors employed, 16 per cent have had a year or more of college education. Forty-two per cent have had four years of high school and 42 per cent have had less than four years of high school. Nearly half of the instructors in schools of nursing have educational qualifications well below those which they demand for the student.

How about the curriculum? What is it that these instructors are teaching? We have some interesting data on that also. I shall take one example. The standard curriculum of the League of Nursing Education suggests that a student nurse should have four months of medical experience. Seventy-nine per cent of the schools schedule more than four months, and 16 per cent schedule eight months or more. Why? Simply because there is work to be done in the medical wards. Furthermore this is what they schedule; what they actually give is very different.

In regard to medical service, one-fourth of all the schools showed a variation of two months between what one student and another in a given class had in medical experience, that is, if the average was four months, one student in the class had three months and another had five months' medical experience. In a fourth of the schools there was a difference of two months in the time given to medical service by students, all of them supposedly pursuing the same course.

Something Is Wrong Here

How far does administrative machinery facilitate the development of educational standards and educational progress? In 38 per cent of the schools the principal was always present at the meeting of the governing board, in 19 per cent of the schools the principal was often present and in 43 per cent of the schools she was rarely or never present at the meeting of the governing board, so that rarely was there any opportunity even for suggestions as to educational procedures to come from the only person able to make such suggestions.

Finally, what are these boards? How far are they interested in nursing education? Out of 1,397



CHRISTMAS GREETINGS

As another year draws to a close, we offer you our best wishes for the Christmas season and for the New Year. ❁ We are appreciative of your friendship and of the patronage you have given us. We pledge our best efforts to make Wyandotte Products and Wyandotte Service of even greater value to you. ❁ As the New Year advances, may it bring you an increasing measure of prosperity and happiness!



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schools about 1,000 have training school committees; 325 schools have none. Only in 883 cases is there anyone on the training school committee who is also on the hospital board and has any authority.

These are a few of the things that the recent studies have shown us with regard to the present status of nursing education. They make it clear that nursing education on the whole is carried on without reference to community needs; that it is flooding the market with poorly trained nurses for whom there is no place; that it is also ineffective and poor in quality, and that it is failing to provide the community with the nurses who are needed for the higher types of nursing.

Are the nurses to blame for this? Certainly not. They have labored for fifty years under the most onerous burdens, struggling patiently and persistently to try to improve the situation, and they have made marvelous progress, considering the difficulties they have had to face. Are the hospitals responsible? Most certainly not. The hospitals have in many cases been more than generous, more than farsighted, in planning wisely and broadly to do the best they could with the resources at their disposal. It is generally known what the better hospitals are doing and how extraordinarily good is the education that they give, considering the circumstances under which it is given.

Nursing education will always owe a great debt to what the hospitals have done during the past fifty years. The community will always owe a great debt to the hospitals for having done it. Yet, we must face this fact. The hospital is not primarily an educational institution. It is an institution for caring for the sick. Its funds were given to it to care for the sick. It has, perhaps, little legal right to divert those funds for the purpose of educating nurses, although in many cases it has undoubtedly done so. It is faced with the one alternative of either exploiting the nurse and neglecting to give her the educational advantages that it morally guarantees when it admits her or else the other alternative of using money given for the care of the sick for a different purpose.

A Serious Educational Business

All of the studies made by the National League of Nursing Education, the Goldmark Committee and the Grading Committee lead up to one point, and that is, that the training of nurses is a serious educational business. This means that it must be attacked as an educational business by those who are interested primarily in nursing education, and we shall never effect more than compromises or halfway measures until this is done. As long as the training school depends for its whole success and whole policy and whole resources upon what the

board of a hospital can spare from caring for its sick, it will never reach the ideals of education.

Any educational enterprise must be directed by a group of persons primarily interested in education. Yet that does not mean divorcement from the hospital. We have worked all of this out in medical education and I think that medical education can hold up its head and offer itself as a model. We have been able to arrange for the use of the hospital as a training ground in the closest and most intimate fashion, and still to have the medical school itself under the direction of persons whose primary interest is in education.

How Yale Educates Its Nurses

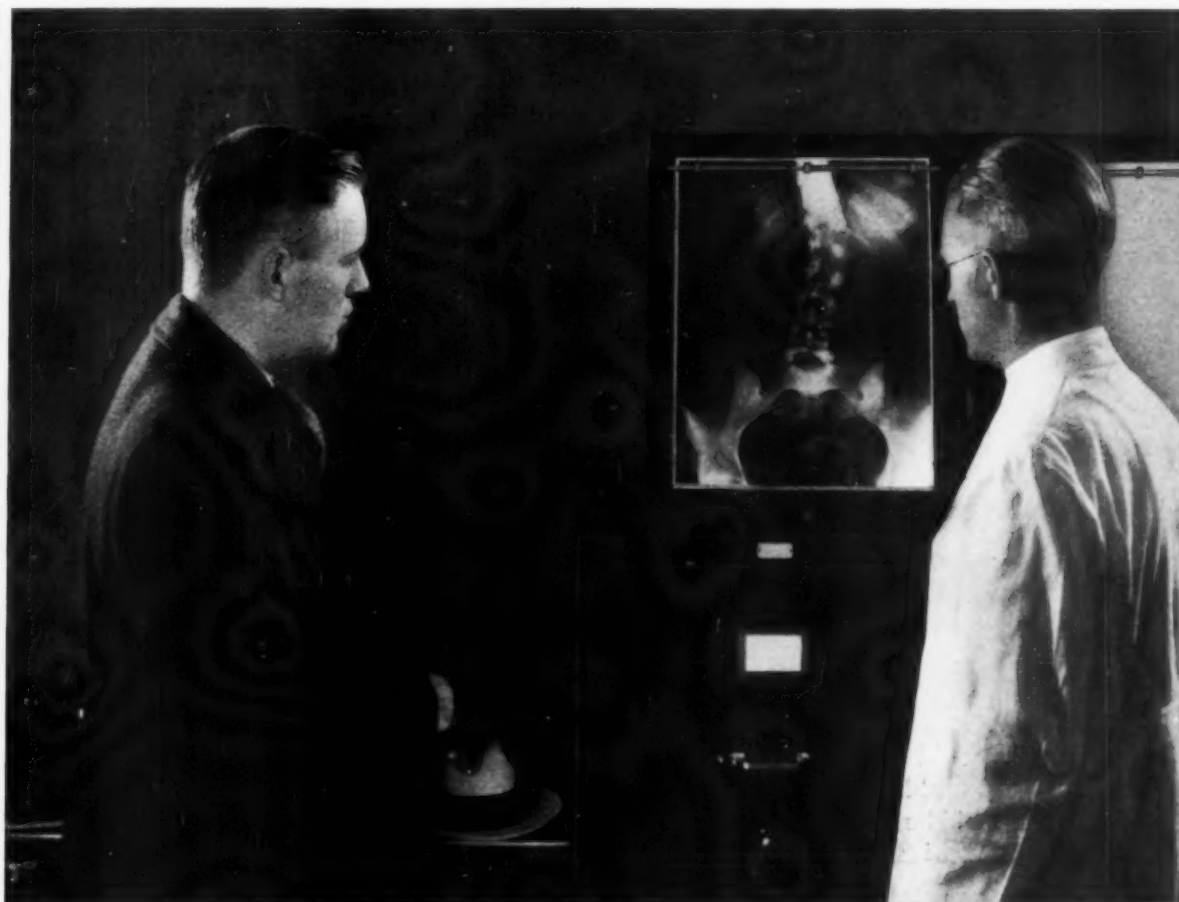
The same thing, of course, has been done with nursing in some instances. At Yale University the hospital is a private separate institution; it has a contract with Yale University by which all the members of the medical staff are named by the university medical school and those of the nursing staff are all named by the school of nursing. We have the closest contact with the practical ward training, which is essential for the doctor and the nurse, but we have, for both, independent educational guidance. That is the first step in our answer, and it must, I think, follow that the training of nurses is a serious educational business. If it is, it cannot be carried on as a casual by-product of the care of the sick.

One wonders what would be the effect upon the hospitals of the adoption of such a theory. Suppose it were accepted that nursing education was a separate problem and that hospitals could no longer primarily depend upon pupil nurses to care for patients. It is hard to say what it would mean, because there are few exact data.

Eighty-seven per cent of the training schools studied by the Grading Committee had no budget, no sum of money set aside at the beginning of the year to be used by the school during the year. Seventy-six per cent of them said that they did not know what it cost to operate the school. The other 24 per cent thought they did, but I am sure from my knowledge of hospital financing that most of them did not. I do not believe that there are more than half a dozen schools in the country that really have any approximate idea of what the school costs them, separately and distinctly from the operation of the hospital. I doubt if anywhere the problem has been fully worked out so that one can say with real exactness, "This is what the training school contributes to the hospital in terms of hours of service, and this is what the hospital contributes to the training school, in terms of food, lodging and instruction." However, 76 per cent of the schools did not even claim to know what the school

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was costing them, so it is hard to say what would be the effect upon the hospital, the small hospital particularly, of abandoning its so-called school.

The Grading Committee has been attempting to find out something more about this matter. We obtained data on about a hundred hospitals, in each of which someone in authority attempted to make a careful study of what their pupil nurses did and an estimate of how many graduate nurses and how many ward maids would be required to replace ten pupil nurses. Their estimates varied all the way from four to eleven; most of them thought about six. There was one curious thing, however, that emerged from this estimate. In every one of these hospitals someone in authority had watched the nurses' work in the ward for a week and had tried to estimate carefully just what part could have been done by a ward maid and what part by a graduate nurse. The larger group thought that it would take about six persons to do the work of the ten pupils, but this was the astonishing thing—one hospital thought the work done by the pupil nurses could be done by six graduate nurses and no ward maids, and another hospital thought this work could be done by six ward maids and no graduate nurses!

We may make a reasonable guess, however, that in most schools or hospitals the dropping of the so-called school would not make much difference to the hospital. In some hospitals it might mean a substantial economic loss, but when this is true it is perfectly clear that the hospitals are parasitic in regard to their pupil nurses. Hospitals that are doing the most for their nurses undoubtedly could effect an economic saving by substituting a proper proportion of graduates and ward maids for nurses. On the average I think the opinion of those who studied this question is that it would not make any great difference. Even from the standpoint of cheap labor this policy of running training schools has been a mistake.

One Way to Solve the Problem

Human beings are curious things. They start on a policy with probably a good, solid, "hard-boiled," selfish motive, and then strange emotional instincts arise within them and they want to do the task better and to do something for other people, so that they are not true to their basic selfish instincts. The hospitals have failed in this respect to be really "hard-boiled." They have begun to try, at least, to do something for these pupil nurses, and I think that the development of a sounder general program by the closing of possibly 1,000 of the 2,000 schools would probably not bankrupt the hospitals. Of course, the closing of the smaller and poorer schools would solve only one

side of the problem. It would solve or help to solve the problem of the overproduction of nurses, though even then it would have to be combined with a limitation of numbers on the part of the better schools.

The tendency to-day rather is for a decrease in and an abandonment of the smaller schools, and an increase in the number of students in the bigger schools. Hence this problem of numbers is not one that those who represent the better schools can dismiss from their minds. It is probable that even the best schools ought to consider seriously the question of whether they are turning out more than their proportion of the number of nurses that their community can be fairly asked to absorb.

This is, of course, only one side of the question. The other side is the provision of training schools that can turn out the nurses who are needed for the higher places. This can come only by a well thought out curriculum moderately adhered to; it can come only by sound basic training with laboratory work in subjects such as chemistry and bacteriology; it can come only through full-time instructors trained for their work, each instructor not teaching, as is now the average, six different subjects. Hence, the training of nurses is a serious responsibility that costs money.

How a Central School Might Function

This fact has begun to be recognized. There are at present about twenty university schools of nursing that have at least some independent, financial or educational backing. We are particularly proud of our school at New Haven, because it is not only a university school but an independent part of the university of equal rank with the school of medicine and the school of law. There are a number of university schools that have educational guidance and direction and at least some funds, but we need a great many other kinds. The university school cannot solve this problem in its entirety.

It was a great misfortune that when endowments were given to university schools of nursing other experiments were not initiated. We need an endowed school of nursing in connection with a well managed, large municipal hospital. We need a school of nursing that will serve as a central school for a number of small hospitals in a community or even in a rural area. Remember that many of the small hospitals that are running poor schools would prove to be satisfactory training grounds for the clinical experience of pupil nurses if they had adequate supervision and control from a primarily educational body. I dream of a central school where the preliminary laboratory work and theoretical work would be given, and which would then be affiliated with ten, twenty-five, forty or

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fifty hospitals, would supervise them and see that the students received a rounded training.

We need various experiments, the ones referred to and many others. All the schools need money; they all need endowment, and that is the basic question that cannot be escaped. We shall talk around and around this question indefinitely until funds are secured for the independent support of nursing education. It may be said that this is not a good time to talk about raising funds, but in any case, the problem we are considering, the future endowment of educational institutions, is not limited by present conditions.

It is difficult for me to understand why this cause does not interest women more. Here is the one career outside of the arts where woman is supreme. In all other fields, in medicine and law there are handicaps, but nursing is one of the great social fields of modern life created by women. Isn't there an appeal in that, and aren't there women who can be stimulated to comprehend it? There are plenty of women with money or with the control of money who could help, and I thought in 1923 that many of them would say, "Why is this peculiarly woman's profession discriminated against?" and would provide funds to carry this movement forward.

It has been decided that physicians are a necessity, and money has been poured out for medical education on a scale that makes some of us feel that it is a tremendous responsibility. Legal education, education for pharmacists, technologic education and dozens of fields of professional education are well provided for in proportion to the quantitative needs. Now isn't a nurse a necessity of modern life, and should not the community have financial provision for supplying this necessary agent? Isn't the Red Cross nurse behind the battle front a necessity? Isn't the Red Cross nurse a necessity at time of flood and fire?

The Nurse's Place in Modern Life

Don't we need those women? Don't we need the bedside nurse in the home whose skill and acumen in watching symptoms and in anticipating needs may in many instances make all the difference between life and death, and, always, between suffering and comfort? Aren't the hospital administrator and teacher necessities? Think what has happened to our hospitals since the old days of dirt and filth and vermin. Who is responsible for this? Mainly the nursing administrators, mainly the successors of Florence Nightingale who have transformed our hospitals. Isn't the public health nurse of the Frontier Nursing Service a necessity, going on horseback through the Kentucky mountains in districts where there are no automobile

roads and no doctors? Aren't her sisters, working in villages in Yugoslavia, among the veiled women of centuries-old Mohammedan Macedonia, or doing the child welfare work of that extraordinary infant welfare association in Hungary performing equally necessary work? All over the world they have spread, in city and in country, in their blue or gray uniforms, climbing the stairs of tenements and going through all the perilous ways of our great cities.

I believe the time will yet come when some part of the great flood of wealth that is coming to education and to social service will flow into the channel of nursing education. Some perhaps can give it themselves, some can reach those who can give, but let us put this subject of securing endowment for nursing education first and foremost in our social program. I believe there is no other single thing in the whole field of education that so much needs to be done.¹

A Glimpse at Industrial Therapy at Anna State Hospital

Down in southern Illinois, well within the triangle sometimes called Egypt, lies the town of Anna. Just outside the town is the Anna State Hospital for the mentally ill.

The grounds, naturally beautiful with fine lawns and grand old trees, are well kept, and cement drives and walks connect the buildings. The patients at present number 1,938.

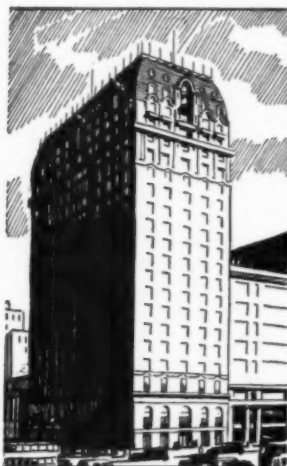
Fannie M. Worthington, associate editor, *Welfare Bulletin*, describes the industrial activities at the hospital as follows:

"The industrial therapy shops for men are well equipped and admirably conducted. Excellent gates and wagons are made there for all the state institutions as well as many good pieces of furniture, such as bedsteads, chairs and tables, racks of various sorts, wicker stools and other household articles. They weave rugs and make rugs of burlap and of worked over wool.

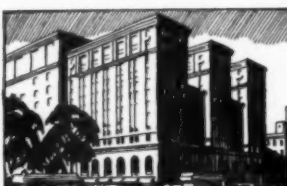
"The industrial department for women is immensely interesting. They sew by hand, quilts, sheets and pillow cases for local use—some decorated with hand done embroidery and lace. The dressmaking room is particularly attractive because the patients select their own materials and designs for their dresses, cloaks and hats.

"Such recreations as picture shows, dancing, golf, croquet and other games are useful adjuncts to the treatment of the patients and assist greatly in hastening the cures."

¹Read at the meeting of the Illinois State Nurses' Association, Chicago, Oct. 14, 1931.



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FOOD SERVICE AND EQUIPMENT

A Series by KATHERINE MITCHELL THOMA, Dietitian, AND HERMAN SMITH, M.D.,
Superintendent, Michael Reese Hospital, Chicago

Analyzing and Inspecting the Weekly Food Bill

AS WE outlined in our first article, we shall discuss the detailed functions of the dietary department of a hospital. For those who did not read this article we wish to define the dietary department as one that has complete charge of food in all its phases, the supervisor of which has the status of a department head. The best outline of the functions of a dietary department seems to be that given by Dr. M. T. MacEachern in which he states that a properly functioning dietary department is correlated with the three major phases of the hospital work: (1) administration—supervision of the general food problem; (2) medical—the scientific dieting

of patients; (3) educational—the teaching of patients and student nurses.

As these articles are supposedly of joint interest to dietitians and administrators, we shall stress only the first two functions and leave the third or educational as one that is of primary interest to dietitians and superintendents of nurses insofar as the education of nurses is concerned and to dietitians and physicians insofar as the education of patients is concerned.

These articles are not written in an encyclopedic manner but are of a practical nature and presuppose a working knowledge of the subject.

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ment must have a definite budget which covers (1) personnel, (2) equipment replacement, (3) supplies and (4) food.

A budget to be worth anything at all should be adhered to neither too rigidly nor too laxly. More important than a rigid or lax adherence to the budget is the mental honesty that is involved in the original making of the budget. The first budget in organizations that previously have had none should be based on past experience: for supplies on previous bills; for salaries on previous pay rolls. In organizations that are using budgets, the previous period's experience is the one upon which the new budget is based, with consideration given to recommended increases and decreases in personnel, and the estimated increases or decreases in the prices of commodities. It should be considered by both the dietitian and the administrator as a working guide to which they should attempt to adhere as far as possible. Variations from the budget are the means of explanation by not only the dietitian but the administrator. The budget should not be pegged so high that to keep within it is an easy task that will reflect unearned credit, or so low that it is impossible of accomplishment.

Making the Budget

In considering the personnel with the dietitian, the administrator should check back, group by group, the functions of the various employees to see whether there are workers enough to handle the job, and second, whether it is possible to combine jobs either in or out of the dietary department or to change functions so that equal efficiency is attained with fewer personnel. This again brings into relief the necessity of the administrator's being completely familiar with all details of the work. The working out of the problem in this joint manner will give both to the administrator and the dietitian a better understanding of their joint problems.

The making of an equipment and supply budget should not be difficult. It is based upon the previous year's experience plus the anticipated needs for the ensuing period, plus a minor amount for contingencies.

The food budget, which in most hospitals represents about 25 per cent of the total annual expenditure, is the most important item in the dietary department's budget, and requires not only the greatest initial attention but the greatest continuing interest on the part of all concerned. This part of the budget must be made as all other portions of the budget, on the basis of the previous year's experience.

Expenses for food should be divided into at least a half dozen major items, such as (1) milk

and cream; (2) groceries; (3) fruits and vegetables; (4) meat, fish and poultry; (5) bread and flour; (6) butter and eggs. Up to a certain point, the greater number of divisions that the total is broken into, the easier it is to control. Beyond this point, multitudinous details pile so high that the main points are lost in a maze of detail. The dividing point between too much and too little detail must, of course, be left to the judgment of the individual administrator and dietitian.

At this point, a minor item from the viewpoint of bookkeeping, but a major item from the viewpoint of administration, must be introduced: the analysis of monthly food figures as they are ordinarily available. An analysis of monthly food figures is frequently of little value because in most organizations the compilation of monthly expenses is not available to the dietitian and administrator until there has elapsed an appreciable period after the end of the month in which supplies are purchased, at a time when it is too late to apply a remedy. It is for this reason that the dietitian and the administrator should demand of the bookkeeping or auditing office some type of food bill analysis on a weekly basis so that the previous week's experience, listed under the headings similar to those outlined, may be reviewed not later than three or four days after the period in which the expenses are incurred.

This brings forth one of the most important functions, responsibilities and duties of both the dietitian and the administrator—the weekly food meeting. At this meeting there should be present the dietitian, the administrator, the purchasing agent if there is one and the dietitian's assistants and the administrator's assistants if there are any. The main subject matter of these meetings is the presentation and discussion of the previous week's food experience in terms of dollars and cents, and in terms of consumption insofar as it is possible. This is not the place to outline bookkeeping methods of the presentation of data. It is enough to say that for these meetings there should be available actual costs of food either purchased or distributed, or both, according to the system in vogue in the particular hospital.

Figuring Per Capita Costs

These figures should be compared with the weekly budget for the various items. In the intimate study of these figures and the bills supporting them, the purchaser notices changes as soon as they occur and is able either to counteract them or allow them to continue if that seems best. As a result hectic discussions between the dietitian and the administrator regarding excessively high food bills are prevented as well as general demands that

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Pineapple and Tomato Salad. Peel large tomatoes and cut slices $\frac{1}{4}$ inch thick. Between two slices of tomato, place slice of Libby's center slice Pineapple. Arrange on crisp lettuce. Serve with mayonnaise and a garnish of pimiento strips.

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Pineapple with Ham. Brown slices of ham, and Libby's center slice Pineapple. Arrange slice of Pineapple on each slice of ham. Top with a hot stewed prune. Pour over melted butter. Garnish and serve.

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Pineapple Spanish Cream. Line glasses with Libby's Pineapple Tidbits. Make a Spanish cream of scalded milk, gelatin, egg yolks and sugar—then beaten whites. Cool mixture. Fill glasses. Chill and harden. Top with whipped cream and tidbits.

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in Syrup
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California Asparagus



the bills be reduced. General demands usually mean nothing and are an unintelligent method of procedure. With the figures inspected in detail each week, there will not arise any hurried demands for changes on the part of either person. Most conditions will be so obvious to both that they will be taken care of almost automatically.

Another worth while function of these meetings is to give a proper perspective of the relative cost of the various items that enter into the dietary. Patients are frequently pleased with what at first appears to be expensive foods, such as fresh vegetables or fruits out of season. When one hears that a patient is requesting strawberries in November or something equivalent, one is likely to believe that the cost of catering to such patients will wreck the budget. When one sees the weekly figures for these supposedly expensive items, however, one is frequently surprised at the small amount expended for them, and realizes that it is frequently possible to satisfy these requests with little if any increased expenditure. The advantages of patients' satisfaction are obvious.

One should not be led to believe that as weekly food meetings go on and it is found that budget limits are not exceeded, everything is as good as can be. Both the dietitian and the administrator should be continually alive to new sources of supplies and to the possibilities of different methods of preparation and distribution, which may encourage increased efficiency and effective economy.

Figuring Per Capita on Monthly Basis

One must not lose sight of the monthly food expense figures in the pursuit of weekly figures. It will be found to be usually more convenient to figure per capita cost on a monthly rather than on a weekly basis. Whichever way the per capita is figured, it should be given consideration not only for its final figure but in its component parts. One should examine the per capita for each item of food, such as milk and cream and groceries, and the details of support days in order to watch the changing relationships between the patients and the personnel.

In discussing per capita we are both frankly throwing a "Sop to Cerebus" because actual per capita, to our minds, is not of tremendous importance. It is well known that the make-up of support days is so different in various institutions that comparative per capitas are entirely non-comparative. The actual expenses for food in its various component parts are far more important than its per capita cost. If one depends too much on per capita figures one may become too easily satisfied. In months in which hospital days may be high, food expenses may be excessively high

even though there is no increase in per capita. It is well known that there is so much leeway in the food expense figure in most hospitals that the actual cost of food should not vary with each change in census. One knows that so much of the food cost is expense for the unchanging item of personnel meals that marked differences in expense cannot usually be explained by moderately changing the numbers of patients.

The intelligent analysis and inspection of the total weekly food expenses will usually give more accurate information and serve as a better operating guide than monthly or weekly per capitas.

What the Physician and Dietitian Think of Each Other

What the physician thinks of the hospital dietitian and what the dietitian in turn thinks of the physician are set forth in an article in the *Journal of the American Dietetic Association*.

The physician thinks that the dietitian lacks personal contact with the patient and thereby fails to grasp his viewpoint; that she lacks ability as a cook and fails to see that the food is properly prepared; that she becomes too involved in routine and administrative duties and allows herself to become hemmed in by routine special diets such as "house," "low residue," "high residue," and "high vitamin"; that the dietitian's organization lacks flexibility; that she is failing to recognize the value of a psychological approach to the patient and does not properly consider the effect of the emotions on digestion; that she does not give adequate instruction in diets to private patients before they leave the hospital.

On the other hand, the dietitian feels that the average physician is too busy or too ignorant, or both, properly to supervise diets. He fails, she says, to encourage suggestions from the dietitian, is often authoritative and obstinate, resents interference and will not admit his ignorance. He pampers his patients and will make any adjustment to keep the patient happy, even though in so doing, he fails to cooperate with the dietitian and perhaps even puts her in the wrong light. Frequently he gets carried away by food fads because he lacks adequate knowledge for discriminating judgment. He fails to impress the hospital administration with the importance of therapeutic diets. Too often, she concludes, he gets the idea that the dietitian is running a short order restaurant and should supply every whim of his patient immediately.



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Preventing Oxygen Starvation by New Portable Equipment

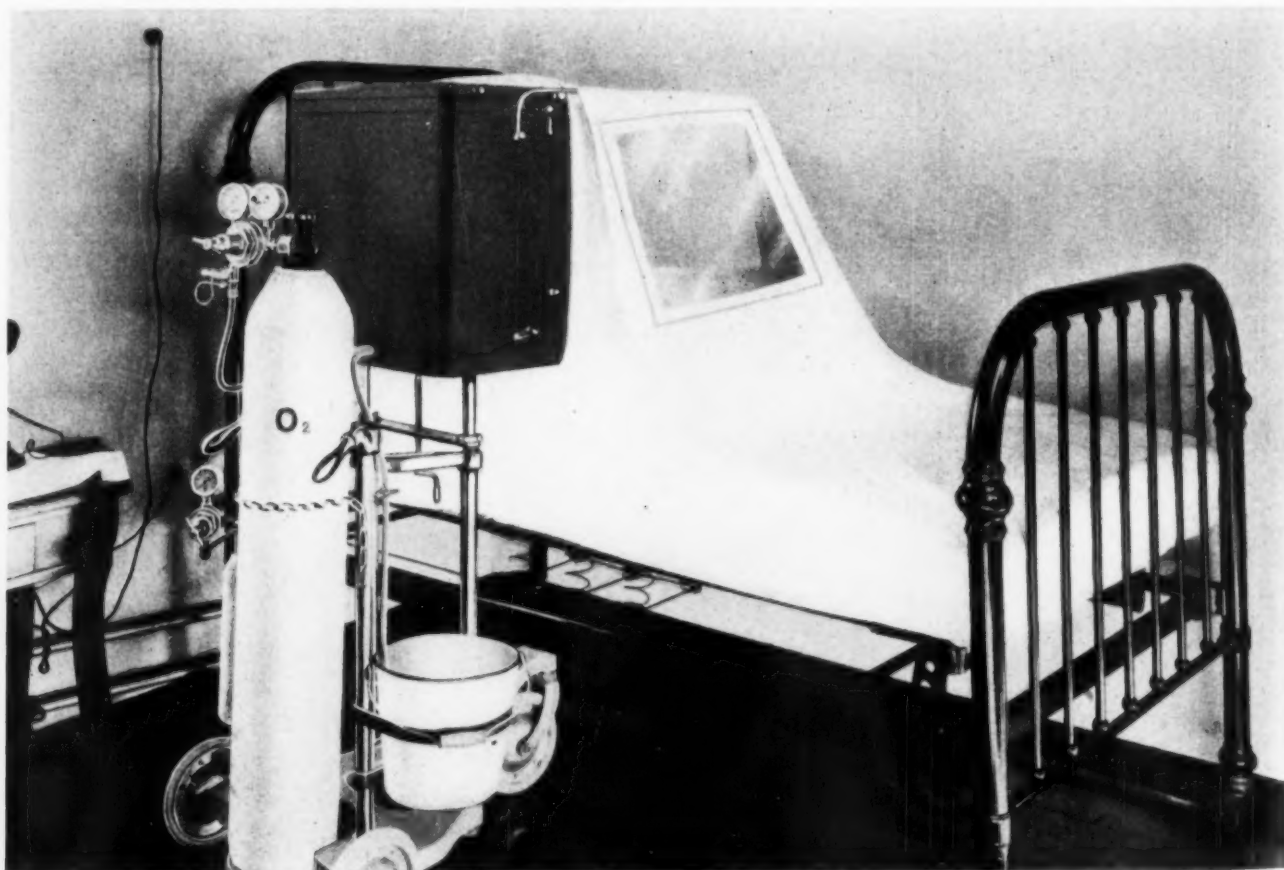
WITH the constantly increasing realization of the value of oxygen in treating various diseases, especially pneumonia, hospitals throughout the country are installing apparatus for the administration of oxygen. Those hospitals that do not already have oxygen therapy equipment available are planning to buy in preparation for the "pneumonia season."

The apparatus that the hospital acquires must be absolutely reliable, available for instant use.

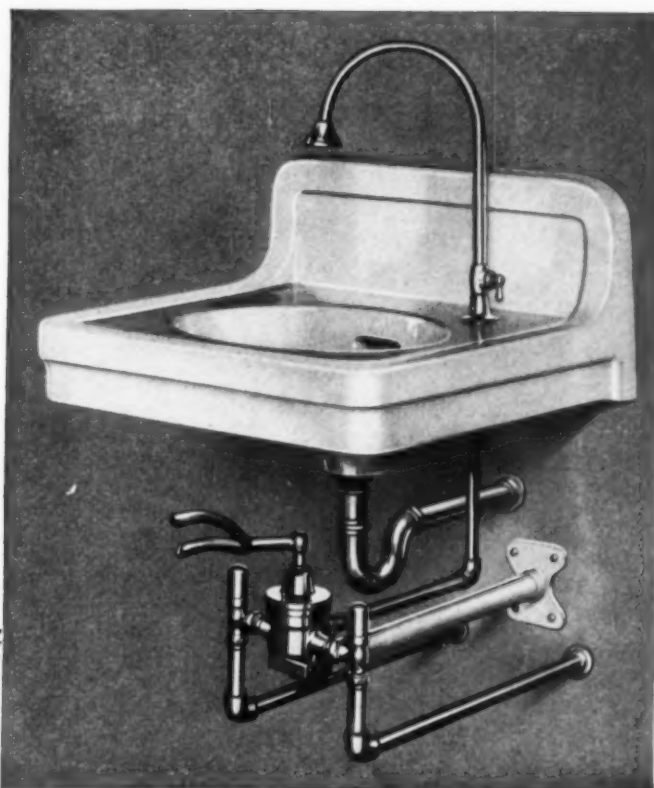
Such a machine has been perfected at a cost that is within the means of the ordinary hospital. It is compact and portable and easily operated by one nurse.

This equipment has the following outstanding advantages:

1. Safe, efficient operation without machinery of any kind. Air and oxygen are cooled and circulated by convection.
2. Absolute temperature control with reduc-



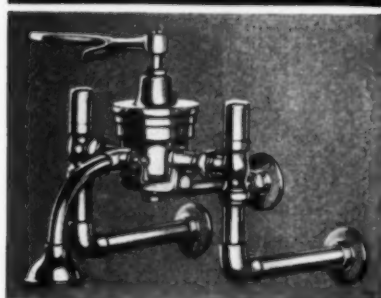
This new oxygen apparatus can be used at any bedside.



*At Side—
Illustrating HN 100 Niedecken Knee Type Control, installed with lavatory complete, including HN 160 Goose Neck Spout.*

*Upper Left—
Illustrating Niedecken Elbow Type Control. Many advanced features.*

*Lower Left—
Illustrating Niedecken Foot Type Control. Many advanced features.*



*Write now for Catalog HN 230
Dept. M. H. fully illustrating
and describing Niedecken Lavatory Control in detail.*



NIEDECKEN

Trade Mark Reg. U. S. Pat. Office

Surgical Lavatory Control

KNEE, ELBOW OR FOOT . . . with the famous Niedecken Mixer as the basic advantage: running water at any temperature, and eliminating need of basin drain plug. Installed in many prominent hospitals.

The Niedecken Mixer is recognized as the most efficient and thoroughly reliable water tempering control: furnishing with *one valve action* water of the temperature desired by the user. The water temperature change is gradual . . . from cold to warm to hot, as desired; and similarly from hot to warm to cold. This not only obtains flow of water exactly at the temperature desired more quickly and more conveniently, but also procures economy in hot water used per year.

The mere movement of the knee, elbow or foot lever brings the flow of water instantly at the temperature desired . . . eliminating also need for basin drain plug, and insuring constantly fresh, clean water always. Another feature (patented) is the Niedecken Regulating Stop—which allows to set water flow at maximum temperature desired, preventing possible scalding, and discarding need for thermostat control on each fixture.

HOFFMANN & BILLINGS MFG. CO.
MANUFACTURERS SINCE 1885
MILWAUKEE, U. S. A.

**RUNNING WATER
AT ANY
TEMPERATURE**



BARACH-DAVIDSON OXYGEN TENT

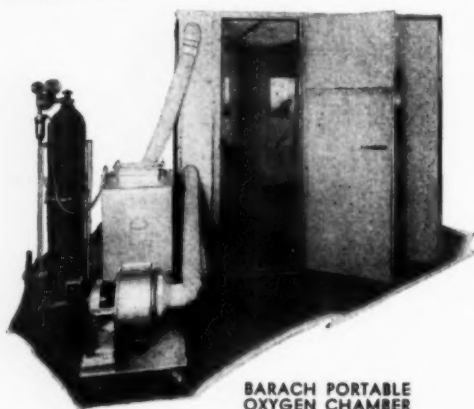
QUIET, sound-proofed motor, silent in operation;

- (2.) Automatic control of temperature and humidity;
- (3.) Wide range of air movement, from three to 45 cubic feet per minute for adult and infant work;
- (4.) No soda-lime necessary;
- (5.) Ice change only once in twelve hours;
- (6.) Large, comfortable hood, equipped with two full-sized windows for free vision.

For PNEUMONIA

Cardiac decompensation, coronary thrombosis, asthma and other cardio-respiratory illness.

- (1.) Economy of operation (costs approximately \$10 per day); (2.) No soda lime necessary; (3.) Easily portable;
- (4.) Ice change once in twenty hours; (5.) Provides the same conditions as a permanent oxygen room, at extremely low cost.



BARACH PORTABLE OXYGEN CHAMBER

OXYGEN THERAPY SERVICE, Inc.

133 East 58th Street
NEW YORK CITY

BRANCHES:

Philadelphia, Detroit, Pittsburgh,
Chicago, Alliance, Ohio

RENTAL

SALES

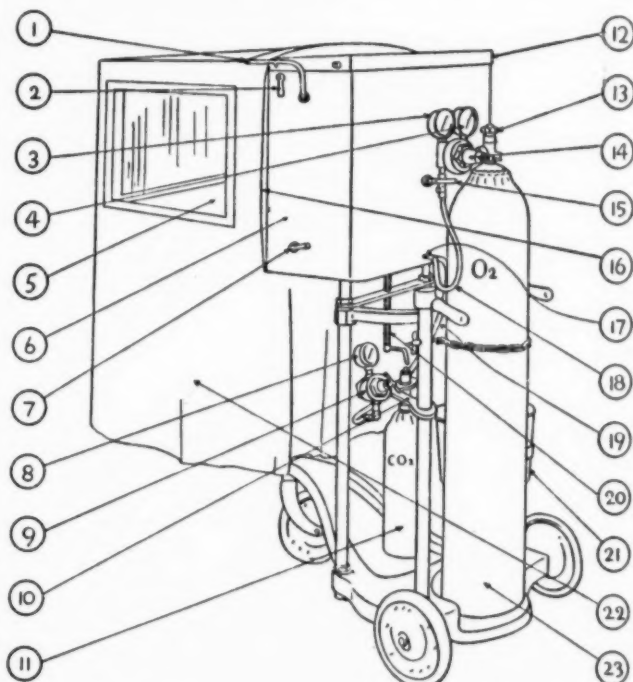
tions from 1 to 20 degrees below room temperature.

3. Comfortable and healthful humidity automatically maintained.

4. Simple operation provides for recharging the ice chamber and the soda lime container without disturbing the patient or interrupting the treatment.

5. The equipment is completely contained on one sturdy chassis.

6. Effortless mobility on large ball bearing



- | | |
|------------------------------|--|
| 1. Curtain rod | 12. Cabinet lid |
| 2. Upper damper handle | 13. Oxygen tank valve |
| 3. Oxygen flow gauge | 14. Oxygen regulator |
| 4. Tank pressure gauge | 15. Oxygen by-pass |
| 5. Window | 16. Channel |
| 6. Control cabinet | 17. "Y" inlet for O ₂ and CO ₂ |
| 7. Lower damper handle | 18. Oxygen hose |
| 8. Carbon dioxide flow gauge | 19. Carbon dioxide hose |
| 9. Carbon dioxide regulator | 20. Elevating device |
| 10. Supporting bracket | 21. Waste pail |
| 11. Carbon dioxide tank | 22. Regular size tent |
| | 23. Oxygen tank |

wheels assures easy handling by even the smallest nurse.

7. Equipped with two complete tents made for years of service. Large windows eliminate isolation of patient.

8. Attachment provided for administering carbon dioxide in accurately controlled volume.

Simple in construction, the machine consists of a portable carriage, a control box, small and large tents, a soda lime screen, an ice chamber, a hydrometer, rubber tubing, an oxygen regulator and a carbon dioxide regulator. All of these form one compact unit. The control box contains the ice chamber and a soda lime screen which may be placed in the path of the circulating air. Dampers in the control box regulate the degree of circulation and cooling of the gases.



Hands Must be Steady

In the operating room, if any place in a hospital, it is important that surgeon, assistants and nurses should be free from discomforts of variable weather conditions. Here, if any place, it is important to eliminate danger of infection through perspiration . . . to control temperature and humidity . . . with York Air Conditioning.

Air conditioning is also important in pavilions, obstetrical wards, premature nurseries, wards for fever patients. It promotes comfort, helps in convalescence, assists in the treatment of a wide variety of illnesses.

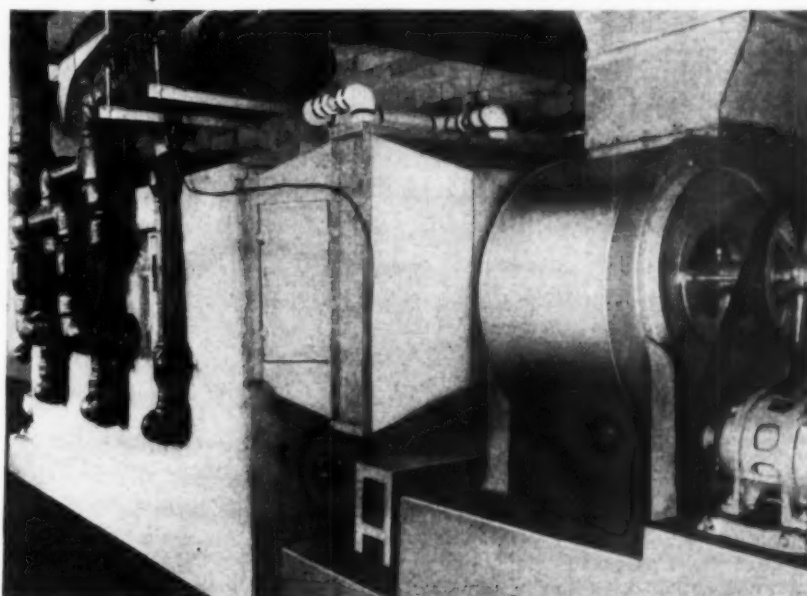
The three most important requirements of hospital air conditioning are . . . simplicity of design, flexibility in installation, dependability in operation. They are also the most notable characteristics of York Air Conditioning and the Refrigeration which accompanies it.

York's half-century experience in manufacturing refrigeration equipment is assurance of sturdy equipment, automatic operation, low initial cost, low cost of operation, up-

keep and supervision. It is also a guarantee that efficient equipment will be co-ordinated into an efficient system to provide all the needs of air conditioning and refrigeration however large and however varied.

Let York serve you. A study of your needs will cost you nothing. Communicate with the nearest of York's 71 conveniently located direct factory branches.

YORK ICE MACHINERY CORPORATION
» » YORK » PENNSYLVANIA « «



York Central Air Conditioning System for hospitals. The air is conditioned in a central chamber and distributed by ductwork to all the departments conditioned. Humidity and temperature are automatically maintained at the varying levels desired.

YORK

REFRIGERATION

YORK ICE MACHINERY CORPORATION
YORK, PENNSYLVANIA

Please send me complete information about York Air Conditioning for hospitals. I understand there is no obligation involved in this request.

Name

Hospital

Street

City

6142-41

FROM ONE DOCTOR TO ANOTHER



**"YES, BURDICK LIGHT BATHS
LEAVE THE PATIENT REFRESHED
... NEVER DEPRESSED"**

—because Burdick scientific ventilation assures quick, controlled diaphoresis at low temperatures. Baths in Burdick Light Bath Cabinets are markedly effective in eliminating poisons, normalizing circulation, and stimulating metabolism in many chronic and convalescent conditions.

The superiority of Burdick Light Bath Cabinets is reflected in their wide use in so many well equipped hospitals. For complete Bath Cabinet literature, write to

THE BURDICK CORPORATION
Dept. 110 Milton, Wis.

Burdick

**PHYSICAL THERAPY
EQUIPMENT**

Over a Thousand Hospitals Enjoy

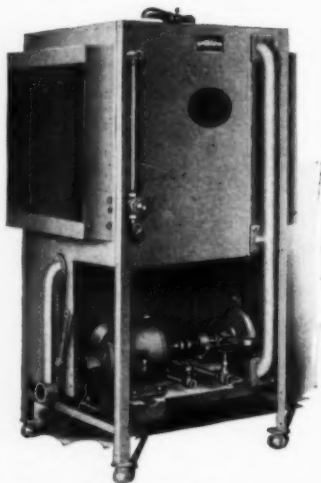
**FEARLESS DISH-
WASHER SYSTEM
ECONOMY**

... Ask them why, and they'll tell you their machine "never-has-to-be-serviced," can be operated by inexperienced help, and uses less soap, water and power. Besides your dishes are kept as free from bacteria as your surgeons' instruments.

Tell us the number of meals served, amount of space available; and you will receive a service plan, with a complete description of the FEARLESS DISH-WASHER best adapted to your purpose.

This will obligate you in no way whatsoever.

Write anyway for descriptive folder showing all Models, and ask your Supply House about FEARLESS Dependability.



Fearless Dishwasher Co., Inc.

"Pioneers in the Business"

175-179 A Colvin St. Rochester, N. Y., U. S. A.
Branches at New York, Chicago and San Francisco

The broad field for oxygen inhalation therapy is best illustrated by the classes of disease treated.

Besides its use in the treatment of pneumonia, under other conditions of "air hunger" or oxygen deficiency, it may be used in the relief or cure of anemia, asthma, atelectasis, bronchitis, burns, diabetes, edema of the lungs, hay fever, hyperthyroidism, insomnia, osteomyelitis, toxemia, uremia, eclampsia, gas poisoning, preoperative and postoperative shocks and certain conditions of the heart.

In the administration of oxygen, there are three obstacles that must be overcome: excessive heat under the tent, moisture thrown off from the patient and a superabundant accumulation of carbon dioxide. The new portable oxygen therapy apparatus has conquered these obstacles.

The operation of the machine is based upon convection, a principle of physics, an ice chamber being used not only to reduce temperature but to provide a natural circulation of air in the tent, which is continued as long as there is sufficient ice in the chamber.

The control box regulates the degree of cooling by means of dampers. Thus, with the ice chamber in the control box filled with ice, the temperature under the tent can be reduced from 1 to 20 degrees below room temperature.

Moisture thrown off from the patient condenses on the cold metal ice chest and on the cold metal inside walls of the cabinet as the air circulates. Humidity under the tent is always less than average room humidity, thus making it comfortable for the patient.

In the matter of excessive carbon dioxide, two solutions are provided. One method requires the use of soda lime, while the other simply requires a slightly increased flow of oxygen and the slight opening of the control box lid to allow the inflow of room air to dissipate the accumulated carbon dioxide.

**Sponge Rubber Mattress Is
Recent Invention**

A New York business man who has made it his hobby to find new uses for rubber has perfected recently a sponge rubber mattress with millions of air cells, so built up that constant ventilation and circulation of fresh air throughout the mattress are possible. This is the basic principle of the invention.

The mattress is made of two sheets of sponge rubber supported by symmetrically placed hollow sponge rubber posts. Thus, full advantage is taken of the resiliency and buoyancy of rubber and air. It is claimed for this new mattress that it is ex-



St. Mary's Hospital, Pierre, South Dakota

WHEREVER THEY GO — they're welcomed back—Efficient service, true quality, at a fair price have won an enviable reputation for

Midland Hospital Products

We are proud of a record of service in a field in which real worth alone spells success.

The buyers of hospital supplies have too much at stake to take any chances on unknown quantities. Midland serves year after year this exacting clientele—and now may we wish you all a very happy holiday season.

**MIDLAND CHEMICAL
LABORATORIES, Inc.**

DUBUQUE, IOWA

A suggestion for the friendly nurse~



For growing children, Horlick's, used regularly, builds strength and resistance to disease. The results of the experiments conducted by the Department of Pediatrics, Marquette University Medical School (Am. Jrl. Dis. Chil. 40:305) indicate that Horlick's Malted Milk, prepared simply with water, adds zest for the regular meals and at the same time nourishes and strengthens.

Horlick's *the Original* Malted Milk

NATURAL AND CHOCOLATE FLAVORS
Samples gladly sent on request



Horlick's - - - Racine, Wis.

IN YE GOOD OLDE CONTINENTAL FASHION

... we wish
a Merrie
Christmas and
a Happie New
Year to our
many friends
and custom-
ers. We ex-



press our hearty appreciation to the many whose regular consumption of Continental Coffee has given us a prosperous year. And pledge ourselves to maintain the high standard of quality which makes Continental products so generally acceptable.

Continental Coffee Co.
INC.

IMPORTERS

ROASTERS

"The Coffee with the Delicious Aroma"

371-375 W. Ontario St.

Chicago, Ill.

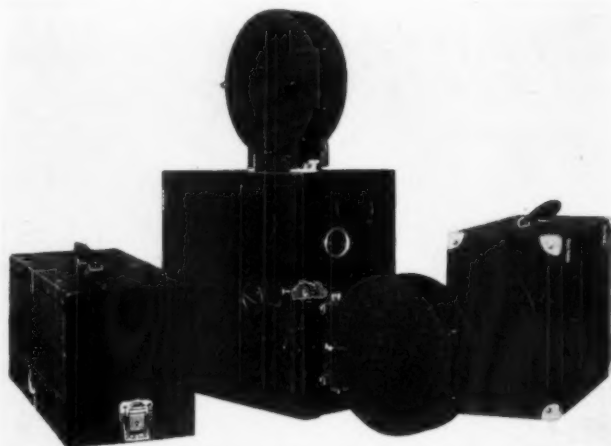
tremely comfortable because it fits the contour of the sleeper's body; that it is sanitary and hygienic because no bacteria, germs or insects will live in it; that it will not sag or become lumpy; that it need not be turned and that the ticking in which it is dressed is removable and washable. It is stated that several hospitals are already among its enthusiastic users.

The inventor proposes to apply the same principle in utilizing sponge rubber for upholstered furniture, chair seats, automobile seats, airplane seats and steamship and railway mattresses.

New Sound Reproducing Unit Has Many Advantages

An entirely new portable sound reproducing unit is now being manufactured on a large scale. The new apparatus has been constructed to serve in any capacity where portable sound reproducing equipment can be employed to best advantage.

The entire unit comprises a projection machine,



an amplifier, a loudspeaker and a carry case for film and these have an aggregate weight of slightly more than 200 pounds. The projection machine is 19 inches high, 19 inches wide and 10 inches in breadth. The amplifier, which is built in a carry case having a removable cover, is 26 inches long, 8 $\frac{3}{4}$ inches high and 11 inches in breadth. The loudspeaker, which is of the flat baffle type, is contained in a carry case, the dimensions of which are 8 $\frac{1}{2}$ by 19 by 14 $\frac{1}{2}$ inches.

Standard 35 mm. film is used and adequate sound reproduction is obtainable in a room or hall having a content of 75,000 cubic feet when using the 8-inch directional baffle. A 6-inch dynamic cone speaker is supplied when the cubic content does not exceed 12,000 feet. A picture about 8 by 10 feet in dimensions is obtained upon the screen from a throw of 75 feet. The equipment is A C operated from an outlet of 105 to 125 volts, either 50 or 60 cycle, single phase power source. The

ARE YOUR TOASTERS USED LIKE THIS ?



If they are, **TOASTMASTER**
will save money in every
diet kitchen



IN MOST hospitals the toasters are actually toasting bread a surprisingly small total number of hours per day. Even during meal hours, orders for toast are likely to be quite intermittent and to vary considerably from day to day. Over the average day the toasters are idle more hours than they are busy.

Toastmaster provides flexible, intermittent operation

One of the big advantages of Toastmaster is that it provides flexible, intermittent operation. During all the moments that it is idle, Toastmaster costs nothing to operate. This is because Toastmaster consumes current only when actually toasting bread. It begins to consume current only when bread is put in for toasting and it shuts off the current as soon as the toast is ready to serve.

Flexible operation with automatic current control is an exclusive Toastmaster feature. How much it will save is shown by actual meter readings taken in many different installations. These show that the saving with Toastmaster, in



4-slice Toastmaster, shown here, makes 208 slices of toast per hour. \$100. 8-slice Toastmaster, \$180. 3-slice Toastmaster, \$70.
Pacific Coast prices slightly higher

comparison with other methods of toasting, runs as high as 59%, or sufficient to pay for Toastmaster each year.

Besides effecting this yearly saving, Toastmaster makes better toast—electric toast—the toast people prefer in their own homes. Toast that stays hot till it's served and fresh and crisp after it's served. In a word, Toastmaster Toast. Toastmaster produces no fumes and practically no heat.

You should certainly know the advantages of Toastmaster. Your institutional dealer will tell you all about them. Or write us direct.

TOASTMASTER

AUTOMATIC ELECTRIC TOASTER

(MADE UNDER STRITE PATENTS)

WATERS - GENTER COMPANY

A division of McGraw Electric Company

Dept. A-12, 219 North Second Street, Minneapolis

Eastern Sales Office: 196 Lexington Avenue at 32nd Street, New York

Chicago Sales Office: 222 West Adams Street, Chicago, Illinois

Pacific Coast Sales Office: 973 Market Street, San Francisco, California



WATERS-GENTER COMPANY, Dept. A-12
219 North Second Street, Minneapolis, Minnesota

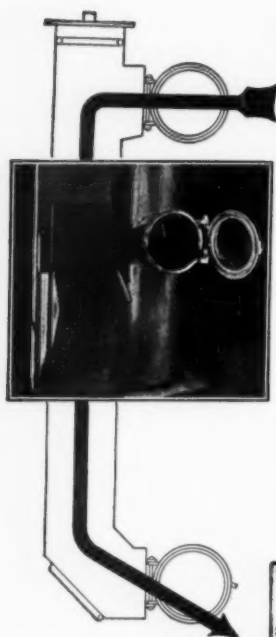
Please send booklet on Toastmaster. Without obligation.

Name

Address

City State

Haslett Dependability Is Tradition—



For many years, in hundreds of hospitals—Laundry & Waste Chutes by Haslett have delivered unfailing dependability. It has become tradition that where consistent efficiency and life-time durability are requirements—Haslett ALUMINUM Laundry & Waste Chutes are invariably specified.

Write for the Complete List
of Well-Known Hospital
Installations

HASLETT
CHUTE & CONVEYOR CO.
Oaks, Pennsylvania

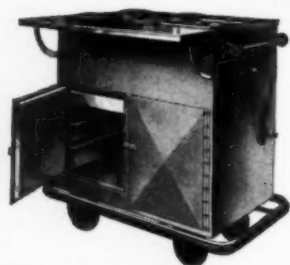
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in Principal Cities



LINEN & RUBBISH CHUTES

FOOD-VEYOR

Request Bulletin
30F for complete
specifications.



Built to serve
individual
requirements.

HOSPITAL meal times often associated with hurried confusion and cold food can easily become quiet, orderly and with service much quicker by using Maforco Food-Veyor, the modern system of Hospital meal distribution.

Proper temperatures are maintained within both hot and cold compartments, thus insuring palatability of all foods. The Food-Veyor may be noiselessly wheeled to all parts of the hospital.

Also manufacturers of all types
of Hospital Trucks.

MARKET FORGE COMPANY
EVERETT, MASS.

Branches in Principal Cities

total power required is approximately 12 amperes at 100 volts.

Connections between the various units are made by means of suitable cables fitted with necessary plugs and receptacles. For a complete set-up using one projector only four cables are required: One is for the power supply to the pro-



The loudspeaker
can be easily
adjusted for op-
eration.

jection machine; one for the power supply to the amplifier which may be plugged into a receptacle in the projector; one to connect the signal circuit of the projector to the amplifier and one from the amplifier to the loudspeaker.

The unit is now in what may be characterized as the "popular price" class.

Cellulose Lacquers and Their Use in Hospital Decoration

That cellulose lacquers are especially suitable for the interior decoration of hospitals, hotels, theaters and restaurants, all of which demand a decorative medium that shall be sanitary, hard wearing and capable of being rapidly cleaned, is emphasized in an article by Major Denis J. Burke in the *Architects Journal*, London, England. Every hour that any of these institutions immobilize any of their accommodation for the purpose of decoration means a loss of earning power. Speed of application and rapidity of drying, therefore, are of the utmost importance.

The article continues:

"Cellulose lacquer and enamel for architectural use have now reached a stage of development that establishes these materials among the proved successes in decorative media.

"Architectural lacquers, which are suitable for

THE ESTELLE PEABODY MEMORIAL HOSPITAL
NORTH MANCHESTER, INDIANA



Garland Heavy-Duty Gas Ranges...

*help this modern hospital
to cut kitchen costs*

The cost of food and the cost of preparing food are two very important items of hospital expense. Sometimes they are interrelated, for unless good materials are properly prepared there is likely to be dissatisfaction and wastage. The fact that Garland Heavy-Duty Gas Ranges have been installed in more than 75 per cent of hospitals and similiar institutions throughout the country is ample evidence of their wonderful cooking qualities. In hospital cooking, the Garland ventilated oven bottom is a particularly important feature. It maintains a constant circulation of fresh, heated air, which makes foodstuffs unusually delicious and appetizing. Garlands are economical too. Some installations have paid for themselves in fuel saved during the first year of use. *Write for catalog.*

—
GARLAND DIVISION
DETROIT-MICHIGAN
STOVE COMPANY
DETROIT, MICHIGAN



Cast in genuine bronze; statuary finish

ENDOWMENTS *in Enduring Bronze are Permanently Recorded for All Time*

A bronze memorial tablet is a courteous and graceful acknowledgment of a generous gift. It is sound business policy as well, exerting a potent influence in encouraging further endowments from other possible donors.

Gorham Tablets in Brass and Bronze

represent the best that skilled craftsmanship can produce. Their cost is moderate, and the many hospitals that use them find them thoroughly suited to their purpose.

The Gorham service bureau will give prompt attention to your request for designs, suggestions and estimates. Address—

The Gorham Company

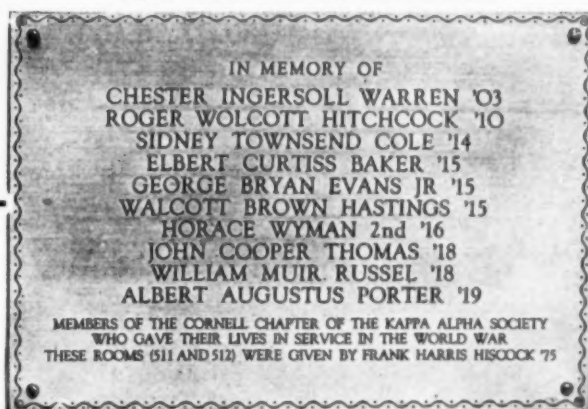
Bronze Dept. N

576 Fifth Avenue

New York City

Address Gorham Hospital Division for information on silverware for hospital use.

Engraved brass; enamel filled inscription



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**12,000 Miscellaneous
Types**

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in the new ...

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Hospital Executives freed from Coffee Criticism

Photograph of St.
Luke's Hospital
Chicago

"In our determination to give our private pavilion patients coffee to satisfy the most exacting taste—we have found Stewart's Coffee, made and served the Silex way, provides flavor, aroma and appetite appeal that has brought most favorable comment, and never a criticism or complaint. We use Stewart's Coffee, exclusively."

Charles A. Wordell, Manager,
St. Luke's Hospital, Chicago.

Stewart's Coffee
is good coffee

Stewart & Ashby Coffee Co., 843-845 W. Washington Blvd.
Chicago, Illinois

All 'phones Haymarket 7181

employment under the varying conditions encountered in their application to plaster, wood, metal, old paint work, large plain surfaces and multi-colored, small or irregular surfaces, divide themselves into two classes—brushing lacquers and spraying lacquers.

"Brushing lacquers suitable for use by the professional decorator are different in composition and working to the brushing lacquers sold in small tins for the amateur painter. They have a much longer brushing time, a much greater covering power and more nearly approximate in methods of application a quick drying enamel. But they have the important characteristic of retaining all the good qualities of lacquer that combines speed of drying with great durability, washability, brightness of color, resistance to disinfectants and other damaging fluids, and resistance to penetration by dirt or stains. Bacteria can be deposited on a cellulose finish but cannot grow.

Other Advantages of Lacquers

"Cellulose lacquers are nonabsorbent and can be scrubbed periodically with water containing disinfectants and further they are not damaged by the fumes of formaldehyde or other disinfectant vapors.

"Brushing cellulose lacquers are particularly suitable for carrying out a rapid scheme of decoration under the normal conditions of paint application. They do not call for a specially trained staff for their application, no special air exhausting apparatus is required to remove the fumes, the odor given off during the drying period is mild and completely disappears in about six hours. Consequently, offices and kitchens can be decorated at night and used the next morning.

"Spraying lacquers are used where great rapidity is called for, large wall areas can be covered in a short time by spraying and the cellulose enamels thus applied dry hard within the hour.

"Admittedly the application of spraying lacquers requires skilled operators, special plant and knowledge of the materials, and such facilities are not available to the ordinary decorator who has neither the knowledge nor the plant nor the necessary staff. Certain firms of decorators, however, have been specializing in this work for some time now and the remarkable encouragement that they have met with will certainly cause others to enter this field.

"Brushing lacquers are in a different category, as they can be successfully applied by any decorator who knows his business.

"Cellulose lacquers combining as they do great durability, an infinite choice of colors, ease and rapidity of application certainly merit the closest investigation by those who are concerned with architectural decoration."



There's eye and appetite appeal in **SAVORY TOAST**

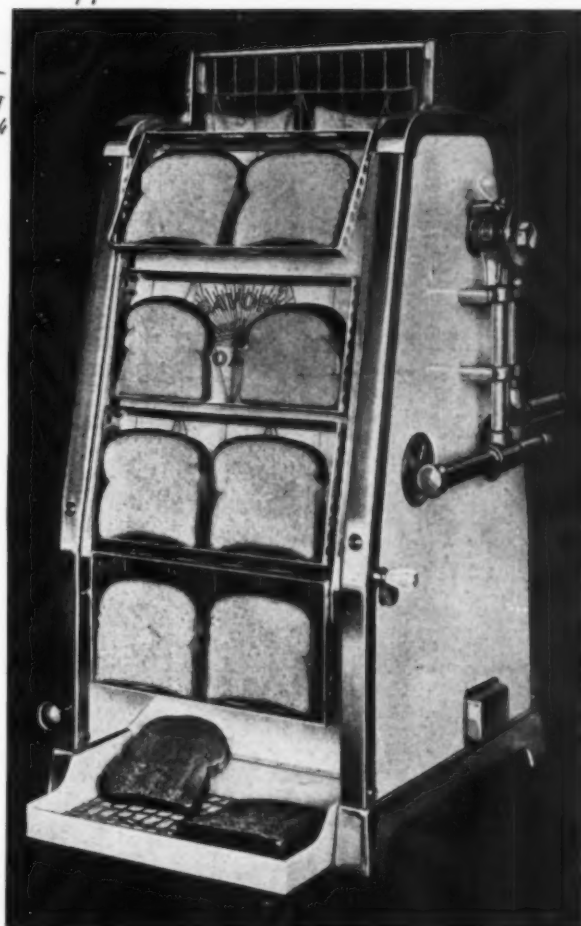
HAVE you ever noticed how often ordinary toast seems to carry a "round-trip" ticket? It goes out to the patient and *comes back to the kitchen*. Not so with Savory toast . . . every slice is soft-centered, evenly browned . . . patients welcome its crisp freshness.

Gas makes better toast cheaper

Here's why Savory toast is so appetizingly different: Moist gas heat first *cooks* the bread . . . imparts the delectable soft center. Then *quick*, radiant heat seals the goodness in . . . carmelizes the moist sugar on the surface. Savory *radiant gas* Toasters cost much less to operate. Using cheap, dependable gas, they provide a continuous production of better toast for only $\frac{1}{2}c$ to $4\frac{1}{4}c$ an hour. And they require less attention while operating, too. Just put in the bread. No need to watch it, nor to be there when it's toasted. A Savory empties the finished toast into a tray at the bottom.

Savory Toasters are first choice among hospitals now building

The majority of hospitals now under construction are installing Savory Toasters. The reasons for this overwhelm-



This popular, hospital-size Savory Toaster makes one slice of better toast every 12 seconds at a cost of only $\frac{3}{4}c$ to $3\frac{3}{4}c$ an hour.

ing acceptance are also the reasons why so many hospitals now operating are replacing their obsolete toast-making equipment with Savory Toasters. Let us send you the names of some of these hospitals and complete information about Savory Toasters. Just fill out and mail the coupon.

MAIL TODAY FOR FULL DETAILS

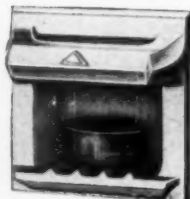
SAVORY, INC., Dept. MH-12
90 Alabama St., Buffalo, N. Y.

Please send me the names of some hospitals using Savory Toasters and complete information about this ideal toasting equipment for hospitals.

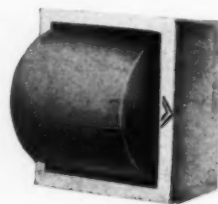
Name
Hospital
Address

SAVORY
radiant gas
TOASTERS

Fairfacts Fixtures



F-152
COMBINATION SOAP
HOLDER AND GRIP



F-2
PAPER HOLDER

Vitreous China Bathroom Accessories cemented into the walls are sanitary, durable, economical. With permanent high fire colors they are unusually attractive and restful.

Fairfacts Fixtures are already used in hundreds of hospitals, and are now being installed in the New York Hospital—Cornell Medical Center. Our long experience, unsurpassed facilities and unquestioned reputation are at your service. If consulted, it will be a pleasure to give you the benefit of our experience. Ask for catalog.

The Fairfacts Company
INCORPORATED
234-236 WEST FOURTEENTH ST.
NEW YORK, U. S. A.

STERLING

POTATO AND VEGETABLE PEELERS

SILVER CLEANERS AND BURNISHERS

VEGETABLE CUBERS

*Sold through leading kitchen
equipment dealers*

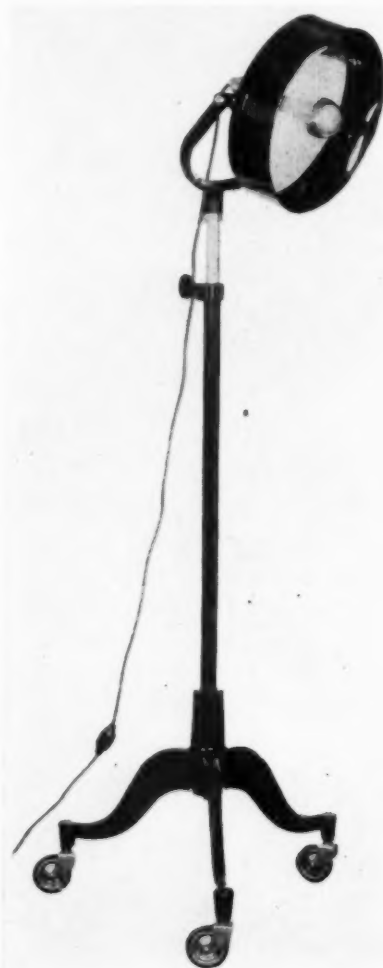
Manufactured by
Josiah Anstice & Co., Inc.
Rochester, N. Y.
New York Chicago San Francisco

A Lamp of Special Merit in the Operating Room

An operating lamp, an efficient lamp with a minimum of heat, has been developed by a manufacturer in cooperation with the staff of the Strong Memorial Hospital of the University of Rochester School of Medicine and Dentistry, Rochester, N. Y., and is being successfully used there.

The following are the general features that make this lamp of special merit in the operating room:

The stand is finished in black enamel and is fitted with rubber tired wheels for easy and quiet



*This operating
lamp is on an
adjustable
stand and has
rubber tired
rollers.*

movement. It is adjustable for height, and the air cushion formed in the vertical column prevents sudden dropping in case the locking screw is unscrewed prematurely.

A standard 100-watt, 110-volt bulb is used. An aluminum cap fitting over the lamp bulb serves as a supplementary reflector.

Experiments conducted with the lamp in a room temperature of 75° F. showed that at a working distance of thirty-two inches, the heat generated is at a minimum consistent with excellent illumination.



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| *No. 30 (Pointed) Surgical Sponges | Combination Rolls |
| *No. 20 (3 x 3) Surgical Sponges | *O. B. Pads |
| *No. 10 (2 x 2) Surgical Sponges | *Kotex |
| *36 x 8 A. B. D. Packs | Ready-Cut Adhesive |
| *18 x 4 A. B. D. Packs | Sliced Bandage Rolls |
| *12 x 2 A. B. D. Packs | Bandages |
| *12 x 12 A. B. D. Packs | Plaster Bandages |
| *8 x 8 A. B. D. Packs | Celluwipes |
| *4 x 4 A. B. D. Packs | Selva Gauze |
| *4" x 3 yd. A. B. D. Rolls | Ready-Cut Gauze |
| *2" x 2 yd. A. B. D. Rolls | Ready-Cut Cellucotton |
| *1" x 1½ yd. A. B. D. Rolls | Absorbent Wadding |
| Cellucotton-Filled Combination Pads | Dressing Rolls |
| | Ready-Cut Dressing Rolls |


*The dressings starred above are in accordance with the list of dressings recommended by the American College of Surgeons

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